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ABSTRACT

This booklet contains both the proceedings of a conference on the rural elderly and the testimony submitted to a field hearing of the U.S. House of Representatives Select Committee on Aging, which was conducted during the conference. Papers presented examine the nature of rural areas and the rural population, services available for the rural elderly, and the need for services and support in a depressed economy with limited medical and social resources. Particular attention is given to health care needs of the rural elderly, mental health services, long-term care, and support for rural caregivers. Other papers consider rural transportation, telephone and other communication services, rural minorities, and rural housing. Groups proposing to help include the rural church, families and friends, community colleges and universities, business development groups, and volunteers. Several papers describe successful programs that have addressed problems of the rural elderly by providing case management, information, referral, and legal assistance. Recommendations emphasize community organization and participation with coordination at the state and regional level, focus on economic development, interagency cooperation, and increased publicity about available services. Testimony given in the field hearing on June 13 describes the situation of the rural elderly in Kansas and Iowa, their numbers, living conditions, health care needs, and suggestions for legislative help. (DHP)

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BEND THE TREND

MEETING THE NEEDS OF THE RURAL ELDERLY

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THE UNIVERSITY OF KANSAS

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Bend the Trend

Meeting the Needs of the Rural Elderly

Division of Continuing Education
The University of Kansas

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FOREWORD

"Bend the Trend, A Conference on the Rural Elderly," was held June 12–14, 1988, in Pittsburg, Kansas. The major sponsors of the conference were Congressman Bob Whittaker, 5th District, Kansas; the University of Kansas; Pittsburg State University; the U.S. Administration on Aging, Regions VI and VII; the U.S. Public Health Service, Regions VI and VII; and the Southwestern Bell Telephone Foundation. A list of the other co-sponsors can be found in Appendix A, and the names of those who served on the planning committees are listed in Appendix B.

This booklet has two parts. Part I represents my best efforts to provide a synopsis of the major comments and recommendations that were made by the conference presenters and the participants in the panel discussions. It concludes with a statement by Carol Fraser Fisk, Commissioner on Aging, portions of which she emphasized in her luncheon address. Part II is the testimony that was submitted to a Field Hearing of the Select Committee on Aging, which was conducted during the conference.

It should be noted that **not all comments and recommendations that have been recorded are necessarily endorsed or supported by the University of Kansas or any of the other sponsors and co-sponsors**. The purpose has been to capture as much information as possible from the conference with the hope that it will be valuable for those who are considering new initiatives or plans of action for the improvement of programs for the aging.

Those of us who helped organize the conference are very grateful to the fine speakers and panel members. They sacrificed time from their busy schedules to share their knowledge and insights to make the conference a success.

I particularly want to call attention to the efforts of Congressman Bob Whittaker and the administrator of his Emporia office, Linda VanderVelde. Their leadership in this effort was vital. Richard Burnett, Greg Wilder, Bill Weisent, and Bob Florance, Administration on Aging, Region VII—you put together an outstanding program. To the members of the two planning committees, whose advice and guidance were so important, many thanks. And certainly the work of Sandra Beal, ASK Associates, Lawrence, Kansas, Dr. Suzan Schafer and Paula York Jason, Pittsburg State University, was outstanding.

To all of you who participated in the conference, thank you for your concern and your dedication to meeting the challenges of ensuring that older Americans, both today and in the future, have a greater opportunity for happy and full lives.

Richard Meyer
Assistant Dean
Division of Continuing Education
The University of Kansas

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INTRODUCTION

America is aging. This graying of America is one of the most significant facts affecting us today and into the future. The first few decades of the 21st century will see the total number of persons over 65 years old double in size. By the year 2030, the number of people over age 85 will at least quadruple.

While this shift in demographics affects our whole country, its effect is being felt even more strongly in our small towns and rural areas. The elderly, wherever they live, share the common problems of growing older. But those living in rural areas report a more difficult time coping with these problems than do their urban neighbors.

Many of these problems center on geographic isolation and the lack of access that usually results. Distance and low population density magnify the difficulties of inadequate medical care, low retirement income, lack of transportation, and poor housing.

When we think of the geography of the elderly, we often think of Florida or Arizona—retiring in a warm climate. But that picture of senior citizens is misleading. Kansas ranks tenth in the country in its percentage of people over 65 years old. Arkansas ranks third; Iowa fifth; Missouri seventh; Nebraska eighth; and Oklahoma twenty-first.

Even though many of our area's elderly did move south several years ago, we are beginning to see what demographers call "counter-migration." Those people who went to warmer places in their early retirement years to live out the rest of their lives are moving back home to be closer to families and life-long friends. Many of them are moving back to our rural areas. Apparently, the grass is not always greener on the other side of the country!

This change in demographics affects all service areas. Health care and the delivery of health services immediately come to mind. Certainly, health care is an important concern for the elderly, and there are several unique problems in rural health care that will intensify over the next decades if they are not addressed in a meaningful way in the near future.

But growing old in rural America means more than health care. Lack of transportation continues to be a major barrier facing the rural elderly. A 1984 report published by the Senate Special Committee on Aging estimates that between seven and nine million rural elderly lack adequate transportation.

This means much more to them than just not being able to get around like they used to. It means not being able to do the things that most of us take for granted—seeing family and friends, going shopping, visiting the doctor, attending church, being involved in the community.

Take away that transportation and you take away a valuable link between them and the rest of society. Inadequate transportation also means that programs set up specifically for them—adult education, congregate meals and health promotion activities—are under-used by those very groups they are meant to target.

The need for adequate housing continues to increase for our rural elderly. Although the elderly are more likely to live in their own homes than the non-elderly, their homes are more likely to be older and in need of repair.

We are told that many elderly people, especially in rural areas, live in houses that are "too big" for their needs and too expensive for them to maintain. But what options are there? Rural areas generally lack the alternatives found in urban areas. In rural America, it is either your home or a nursing home, with little choice in between.

But rural America also has a tremendous, if often unrecognized, resource. Rural Americans have a strong network of family, church and friends that is unparalleled. This network can provide the needed link between being isolated and being a part of the community.

There is much reason for hope. In June 1988 we gathered more than 250 people in Pittsburg, Kansas, for a conference entitled "Bend the Trend: Meeting the Needs of the Rural Elderly." Involved in the day-to-day provision of services to the elderly, the conference participants gave their views and recommended ways to improve the quality of life for the elderly in rural America.

The participants came from many different areas—housing, transportation, and health services; yet, they shared the common goal of providing services in the best way possible to a segment of our population that is growing by leaps and bounds. Because of their insights, we have a clearer vision of what we can do today to solve tomorrow's challenges.

Bob Whittaker
U.S. Representative
5th District
Kansas

Part I

Proceedings

Robert Van Hook
Executive Director
National Rural Health Association
Kansas City, Missouri

Major Comments

Rural areas are very diverse; they can be classified into four types:

- adjacent to an urban area;
- urbanized rural;
- frontier—fewer than six people per square mile;
- countryside rural.

"Rural" is also a state of mind because of the values and attitudes of residents of rural areas. They:

- value personal independence and believe that individuals are responsible for their own actions, not society;
- are thrifty;
- believe in property ownership, particularly owning one's home;
- distrust large institutions;
- believe in cooperation and volunteerism to solve problems on the local level;
- make judgments on the basis of personal rather than professional characteristics.

The economies of many, or most, rural areas are in a state of stagnation or decline.

Many people cannot pay their bills, and they have limited or no health insurance; the results are great personal stress and financial stress on health care providers.

Local tax bases are shrinking because of declining land values, shrinking populations, the closing of businesses, and the loss of jobs.

Young people, those who could help provide care for older family members, are migrating to urban areas for job opportunities.

Many rural hospitals have closed down because of a decline in admissions and also because they receive about 37% less for Medicare cases than urban hospitals. Many others are experiencing large financial losses for the same reasons.

It is difficult to recruit doctors and other health professionals to rural areas. Doctors in rural areas work longer hours and have 20% more patient visits and make less money than their urban counterparts; yet, their business costs are almost equal with those of urban doctors.

Economies of scale for rural hospitals and clinics often are not possible because of a low population base.

Rural people tend to shy away from taking advantage of the services that are available to them.

Recommendations

Rural programs must be tailor-made, not down-sized urban programs.

Rural values must be respected if programs are to be successful.

Those involved in the planning and administration of programs should know their market by looking at the whole community.

Service providers should:

- expect change and maintain flexibility;
- think strategically;
- act resolutely;
- be willing to make decisions;
- emphasize and ensure the quality of services;
- develop systems of care that tie in with other things that are being done in the community;
- be willing and prepared to cooperate with other agencies and groups;
- take care of the disadvantaged in the community.

Stockton Clark
Office for the Aging
New York State Executive Department
Albany, New York

Major Comments

Rural Roundup, the newsletter of the National Rural Health Association, features information on programs that work and legislation that is being considered.

Older Americans Act — rural is 10,000 population or less.

Census Bureau — less than 50,000 population is non-metropolitan.

Services to the rural elderly will never reach the level of those provided to the urban elderly.

Many people in rural areas have no health insurance.

Although 80% of the rural elderly own their own homes, much of their housing is old (built prior to 1940), has little or no insulation and is in need of repair.

Approximately 7% live in mobile homes and, in warmer areas, some live in shacks.

Many rural hospitals are closing.

Many rural elderly need assistance, but they struggle to stay independent. They consider assistance to be welfare, and they don't want welfare. The "welfare" image of service providers has not been improved by the name changes of agencies and organizations.

More than 35% of the elderly live in rural areas; at the same time, more and more young people are moving to urban areas.

Those who need the most help get the least.

Approximately 20% of the rural elderly are living at or below the government's poverty standards. This compares with 12% in urban areas.

The federal government allocates $29.00 per capita for urban mass transportation, but only $1.00 per capita in rural areas.

Recommendations

Let the elderly know about their entitlement to services. Improve accessibility to these services.

Examine programs that have been successful, e.g., congregate housing.

Allocation decisions should be made as close as possible to the point of delivery of services.

Churches can and should assume a leadership role.

Rural hospitals must be willing to change and help in the creation of a health and human services infrastructure.

Inventory the programs we have; not much more is coming.

The development of community-based long-term care is tied directly to the economic development and survival of rural areas.

Dr. Burl Self
Southwest Missouri State University
Springfield, Missouri

Major Comments

A vision of the future has been one of the sustaining marks of the American rural experience.

The American way of life is a way of acting, not a state of inactivity.

Year 2000 Commission

The Commission was created by Governor John Ashcroft of Missouri in 1985. Thirty people, representing business, civic and volunteer leadership, labor, academia, local education, health care, the media, and state, local and federal governments, were appointed to the Commission. They were charged with the task of "exploring the role of economic development, education, health and quality of life . . . as each . . . relates to Missourians' expectations and aspirations about the future."

Health and Quality of Life Committee of the Year 2000 Commission

Governor Ashcroft charged the committee with the following responsibilities:

- study the relationship of a healthy work force and quality of life in Missouri communities;
- relate those factors to economic growth and development;
- recommend ways to encourage Missouri's communities to maintain a quality of life that supports and attracts business as well as providing better support systems for all citizens.

The committee studied the following topics:

- the impact of a more healthful way of life on business and industry;
- Missouri's changing health care system;
- the state's changing role in indigent health care, housing, and long-term health care;
- rural Missouri;
- mental health;
- women and children in an aging society;
- problems and opportunities of older persons in Missouri's future;

- the impact of family structure on early childhood scholastic performance;
- bioethical issues.

Findings

In the next fourteen years, the average life expectancy should increase up to four years.

Health care costs, especially those tied to new technologies, will continue to rise.

The economy will focus on the need for a better continuum of care and alternative delivery systems, especially in rural Missouri.

Those providing services to the elderly in the year 2000 should anticipate alternatives, including trade-offs, to adequate, affordable health care for all citizens, but especially in rural America.

Health maintenance organizations (HMOs) and preferred provider organizations (PPOs) will dramatically affect current and future health delivery systems.

There will be a greater emphasis on group practice, hospital outpatient care, ambulatory care, and home care.

By 2000, Missouri's elderly population (65 and older) will reach 750,000 persons, comprising 14% of the population.

Planning for possible catastrophic need will be an increasingly important responsibility in the future. Education on the problem must begin during the person's productive years.

Many rural health care problems in the year 2000 will be mostly women's problems. Women over 85 will outnumber men over 85 by nearly three to one. Data from the 1980 census illustrate the makeup of elderly households. Sixty percent of all Missouri households headed by persons 85 and over were women. 8 in 10 of these women lived alone. Their average personal income was less than that of all elderly persons and two-thirds less than that of married elderly people.

It has become obvious that there must be a continued shift of health resources away from the costly and catastrophic experience of nursing home care to alternatives such as home health care and elderly day care facilities.

Recommendations

Private insurers should develop and make available additional and appropriate long-term care policies.

The Missouri Division of Insurance should study long-term care insurance and propose a program that would encourage insurers to extend and expand such coverage.

The Missouri Departments of Social Services and Health should develop and implement programs of information that will stress the importance of families' planning for long term care.

The Departments of Higher Education and Social Services should study opportunities and develop plans for the encouragement and motivation of older citizens, who can and will expand their knowledge and qualifications to better serve the economic and social needs of the state and its younger citizens.

University extension systems should be reorganized to better reflect the economic development focus in rural areas.

Lyn Wallen Ziegenbein
Executive Director
Peter Kiewit Foundation
Omaha, Nebraska

"New Seeds for Nebraska" is an 18-month-long project that has examined economic conditions in Nebraska and prospects for the future. The study was sponsored by the Nebraska Press Association and was funded by the Peter Kiewit Foundation. SRI International, a nonprofit research and consulting firm headquartered in Menlo Park, California, conducted the research and compiled the report.

The study was nonpolitical and was to determine where Nebraska had been, where Nebraska is, and where it is going.

The report generated from the study was disseminated throughout the state (600,000 copies), and more than 40 town meetings were conducted to discuss the report.

Study conclusions probably have good applicability to neighboring states.

Findings

Relocating industries look for a high quality of life when selecting a community.

Twenty-five percent of working Nebraskans are overskilled for their jobs.

Outmigration, particularly of the young and well-educated, is a matter of particular concern.

Urban areas have diversified; rural areas are less adaptive to change.

Small businesses create most new jobs.

Two questions — Can family farming survive?
— Can all small towns survive?

Recommendations

Seven new competitive advantages must be built:

- access to appropriate technologies;
- a more skilled and adaptable work force—7 new careers in a working life can be expected;
- discovery of new ways to make capital available;
- encouragement or fostering of entrepreneurship;
- concentration on improving the quality of life;
- improvement of the infrastructure, particularly communications;
- a competitive regulatory and tax environment.

Industries and educational systems need to dust themselves off and make changes.

Economic development needs to be more than just luring new firms with incentives. Economic development needs to be redefined as the processes we use to rebuild our ability to compete—economically, educationally, even culturally and socially.

Food processing and other value-added industries must be expanded to reach new markets. Food processing is a very fast-growing but also fast-changing sector, with many new entry points for new products and new firms producing those products.

Nebraska and other agricultural states must diversify their manufacturing sectors and reduce, but not break, the link of dependence between manufacturing and agriculture.

A more active effort must be made to capture tourism dollars.

Educational institutions must become more responsive to economic development needs.

Business entrepreneurs may be born, not grown, but they can be nurtured and supported by a public policy climate and by a financial climate that enables them to be successful.

Urban-rural links must be rebuilt.

The economic capacity in communities of 5000 or more must be strengthened. These communities have an economic infrastructure in place. Although incomplete in many cases, there is something to build on. By building capacity in regional centers, the economies of those areas will grow, providing job opportunities for people who want to move from the farm or travel shorter distances to earn off-farm income.

Instead of just trying to muddle through, now is the time to grab hold of our destiny by making tough choices and moving strategically into the future.

William Dreyer
President, Kansas Division
Southwestern Bell Telephone
Topeka, Kansas

Note: Effective October 1, 1988, Mr. Dreyer will be the group president for Southwestern Bell Publications and an officer of the Southwestern Bell Corporation, St. Louis, Missouri.

Major Comments

Services that you and I use every day to get help or information are not used by some rural older adults, simply because they don't have telephone service in their homes.

About five million low-income Americans don't have phone service for a very basic reason—they can't afford it.

As a whole, basic local telephone rates are very reasonable. A good indication of this is that 92.5% of the households nationwide have telephone service; in Kansas, 95.3%.

It's the service connection or hook-up fee that has kept many households from ordering phone service.

Four of Southwestern Bell Telephone's states have taken the lead in a program called "Link Up America." The program is designed to cover part of the costs of installing and connecting phone service for those who can't afford it. Many low-income older adults living in rural areas have received assistance from this program.

Telephone service is a vital medical link in rural areas. Many major metropolitan hospitals have remote medical units in rural areas, which can transmit important medical information across phone lines to major hospitals. Results then can be sent back to the remote locations. Heart rate and blood pressure can be monitored over telephone lines. Even magnetic resonance imaging and cardiograms can be administered from a remote location over phone lines.

A large and active senior population is a benefit for all of us. Older adults have values and experiences that can contribute to both the stability and economic development of our rural areas.

While the demand for caregiving is going up, many of society's traditional caregivers are working outside of the home. Half of all adult women work outside of the home.

We need to pull together to help our caregivers. Awareness is the first step in recognizing caregiving and finding sources to help caregivers. Southwestern Bell is helping to build awareness through a new educational program called "Caregiving: The Challenge of Elder Care," which has three parts:

- a resource manual;
- an audio tape that gives advice and reassurance to caregivers;
- a video tape that provides information from experts and discusses available alternatives and support services.

The program can assist local groups in building coalitions and resources to help caregivers.

Southwestern Bell has also published a resource guide developed by the Administration on Aging called "Where to Turn for Help for Older Kansans."

Southwestern Bell will soon launch a caregivers' educational program in concert with the Kansas Coalition on Aging. The program will assess the needs of caregivers in various Kansas communities and the resources available to them.

Senior 24 is a program that assists numerous older adults and caregivers. This joint project involves Southwestern Bell, the Northwest Missouri Area Agency on Aging and United Way, and is a 24-hour information and referral service that serves older adults living in an 18-county area.

In Ada and Altus, Oklahoma, caregiving coalitions are examining local information and referral services. The Clinton, Oklahoma, Chamber of Commerce and Southwestern Bell Telephone are preparing a Caregiver Resource Directory.

Southwestern Bell Telephone and the Small Business Administration have joined forces to promote rural economic development. This four-phase project has resulted in identifying resources for rural economic development. Resources such as these are stimulating economic development in our rural communities. Older adults are becoming entrepreneurs and, at the same time, sharing their knowledge and expertise with their communities.

Tailoring Services to a Rural Environment

Moderator — *Esther Valladolid Wolf*
Secretary
Kansas Department on Aging
Topeka, Kansas

Presenters — *Shirley Higdon*
Executive Director
Mid-America Council on Aging
Ottawa, Kansas

Tonia L. Salvini
Mid-America Council on Aging
Ottawa, Kansas

Monda Spool
North Central Flint Hills Area Agency on Aging
Manhattan, Kansas

Anne Scheer
North Central Flint Hills Area Agency on Aging
Manhattan, Kansas

Dr. Phil Olson
Director
National Center of Rural Extension and Gerontology
Kansas City, Missouri

Major Comments

Successful rural service programs differ significantly from their urban counterparts; therefore, different kinds of services, priorities and approaches are necessary.

Note: A different opinion has also been given:

Even though service delivery may differ from working in urban or rural areas, it is not necessarily true that there is a significant difference in needs and priorities. The challenge is in the provision of the needed services. Coordination with other agencies, the development of a well-trained volunteer component and computerized information and client tracking systems have been the basis for overcoming some of the "rural obstacles" and "turf" problems.

The proportion of rural elderly will continue to increase in the coming decade, including the old-old, those over 85 years of age.

The old-old are those who are more likely to be frail, dependent or isolated.

A consequence of the increase in the frail aged will be a corresponding burden on the service system in rural areas.

Project RURAL ACCESS, funded by AOA, has these goals:

- developing a cost-effective approach to link current fragmented systems of information, referral, and service delivery;
- increasing accessibility of mental health resources to older adults;
- connecting isolated elderly to enabling services that maintain their maximum living independence.

Note: For a more detailed discussion of the Rural Access project, refer to Monda Spool's testimony to the Select Committee on Aging Field Hearing, pp. 69–71.

The National Center of Extension Gerontology has collected community-based program models in health promotion, caregiving and intergenerational relations.

In 1984, Community Services for the Aging (CSA), a department of the Mid-America Council on Aging, which provides primary access services in addition to other aging services, worked on the development of a client tracking system and an information and referral system. In addition, the Mid-America Council on Aging (MACA) developed fiscal and program management systems for the computer. CSA staffs five fulltime employees and 32 volunteers. Home visits to the home-bound and frail elderly to provide services is routine. CSA targets clients who are 60 and over, frail, economically limited, and isolated due to social and physical factors. The goal is to increase access to community services and to assist the clients in staying healthy, active, and at home—avoiding early or unnecessary institutionalization.

CSA services include, but are not limited to:

- case management—home visits to explain services available in a six-county area. Clients are assisted in problem solving, alternative/option planning, developing a plan of care, including the client in executing the plan, providing monitoring and assistance in form completion, and brokering for services.

- information and referral—the office is equipped to answer most questions regarding information and resources on aging.

- legal assistance—MACA contracts with Kansas Legal Services (KLS) to provide free legal consultation to eligible clients. CSA arranges for the attorney to be available once a month in our office to provide consultation. The attorney also makes home visits on our request. Depending on the nature of the case, the KLS attorney may provide representation on behalf of the client or the client can be referred to a local attorney who participates in the "Participating Attorney Program." This program allows our clients to have access to private attorneys for an initial consultation at a reduced fee. After the consultation, the attorney and client discuss the need for further consultation or representation and negotiate a fee, if appropriate.

- Project Link—this system provides information on people who are available to work in homes for private pay:

  personal care: assistance with bathing, shampooing, dressing and other personal tasks;

  homemaking: assistance with household duties, such as cleaning, cooking, shopping, laundry and other tasks;

  handyman: assistance with home maintenance, such as mowing the lawn, trimming shrubs, repairing household items and other chores.

- monthly newsletter—*The Golden Years* provides an array of current and relevant information regarding aging issues and problems on the local, state and national levels.

- conference sponsorship—CSA plans and prepares programs for local citizens in the six-county area. Conferences are held regionally and in each county. Topics have included division of assets, alternatives for guardianship or conservatorship, long-term care, nursing home care, safety and other topics.

North Central Flint Hills AAA has received a grant from the Administration on Aging to computerize the community services functions in Riley county. This system should help other communities and AAAs to develop strong coordination links with other community agencies.

Recommendations

The nature and extent of the population that is elderly and frail must be determined.

We must develop and operate educational and service programs that draw on local reservoirs of human talent of all age groups.

Service providers in rural areas need to coordinate their efforts and be flexible. However, the problem at times seems to be the strings and limitations involved with their funding sources.

Rural service providers should not reject consideration of urban models, but instead adapt methods of delivery. Often, however, they lack the money, technical assistance and personnel to adopt urban models.

Money and resources should be allocated to develop computerized systems for community services. Computerized databases can help the elderly locate services by making just one phone call or one visit to a senior center.

The Rural Church as a Focus for Community Progress

Moderator *Dr. Brenda Crawley*
University of Kansas Gerontology Center
Lawrence, Kansas

Presenters *Dr. Robert Harder*
Topeka State Hospital
Topeka, Kansas

Dr. Marvin Kaiser
Kansas State University
Manhattan, Kansas

Major Comments

Churches have historically been the focal points for community change. As the need for leadership in rural areas emerges in response to developing trends, rural churches, with their inherent credibility, are in a particularly good position to organize community responses.

There is a theological and Biblical mandate to care for the elderly.

The church should be seen as a community institution.

Christians have a moral imperative to care for the elderly:

- Old Testament—Exodus 20;
- New Testament—Matthew 5, Matthew 22 and 25.

Christian witness cannot be confined to the church building.

The greatest church leaders in history were not passive, but instead offered challenges for change.

Christians who take their responsibilities seriously can obey God's commandments in any community.

If rural areas are to survive, we must depend on the elderly.

Many elderly are not poor, and they will leave the community if they are not supported.

Current mind sets exist that are not supportive of the elderly:

- churches are not doing much;
- we have an "American church";
- local churches tend to *reflect* values, not guide them.

The characteristics of reflecting values:

- lack of theological underpinning; when the leader leaves, the programs fold;
- churches waste time bickering instead of being a resource.

How can churches be a resource?

- Values: we must tie the Biblical message to the life of the community;
- Resources: a majority of churches give to the same kind of social services; most services are very limited;
- Leadership: there is great community dependence on this; it can be negative or positive.

Churches are the greatest untapped resource to serve the elderly.

Progress will result through small intergenerational interaction, not preaching.

The narrower a community defines its bounds, the more negative the entrepreneurial and economic consequences.

Recommendations

Churches should be value leaders in their communities.

There is a perception that when a need exists, *they* are responsible. We need to talk in terms of *we* are responsible.

Many churches emphasize young people's programs. Programs for the elderly should also be established.

Communities should work together ecumenically.

The church body, not the minister, must identify what needs to be done and provide the necessary leadership.

Churches usually can and should provide meals and intergenerational activities, and serve as the "eyes and ears" for nursing homes.

Communities need "salty" Christians who understand values and are willing to penetrate society.

Coordinating Rural Transportation—Successful Strategies

Moderator *Paul Lineberry*
Missouri Division on Aging
Jefferson City, Missouri

Presenters *Robert Krause*
Director, Center for Transportation
The Council of State Governments
Lexington, Kentucky

Ken Malkowski
Staff Director
Transportation & Accounting Consortium
Lansing, Michigan

Major Comments

All surveys of older persons rank transportation services high in priority. Often, they rank number one. Strategies for delivery of rural elderly transportation services are numerous. Fifty percent of rural transportation is demand responsive, e.g., door to door pickup and delivery.

Keeping the elderly transportation-independent helps keep them in their own homes and out of nursing homes. Even relatively high per-trip costs can be justified if they act to prevent institutionalization.

Most community transportation operators are public or nonprofit organizations.

A large portion of federal funding for rural public transit comes from agencies other than UMTA. The expenditures of money from these many pockets (114 in 1977) are often uncoordinated and result in the purchase of much equipment that has low rates of use. An example of change: Iowa has had coordination legislation for almost fifteen years. Twenty-three agencies in that state receive rural transit funding from UMTA. Kansas has 118 agencies that provide rural transit services. Iowa's 23 agencies provide 3 million rural trips per year.

Change at the state government level is a slow process.

There are local and state approaches to the solution of problems. The challenge is to determine how they will work together. A common element in all coordination efforts is a single point where service levels, funding and delivery strategies are reviewed.

Recommendations

It is important to develop a common accounting language for rural and specialized transit systems.

State level programs for the coordination of rural transit should be set up to ensure greater use of existing equipment and to give more service. Coordination efforts must be initiated at the state or regional level to be effective. Usually seed money from the state is required to initiate coordination.

By coordinating efforts at the state and local levels, more can be done with limited resources.

Avoid duplication—try to do more with what you have.

Because of poorer eyesight among the elderly, things like the size and spacing of highway signs must be addressed if the elderly are to continue driving. The analysis of elderly driving factors is embodied in a traffic and sign management philosophy known as "Positive Guidance."

Rural Health-Care Delivery Strategies

Moderator — *Louanah Templeton*
Rural Health Program Consultant
U.S. Public Health Service, Region VII
Kansas City, Missouri

Presenters — *Ross Marine*
Executive Director
Midwest Rural Health Association
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Dr. Steve Pew
Deputy Director
Community Programs for Affordable Health Care
Stormont–Vail Health Services Corporation
Topeka, Kansas

Dr. Larry Wolgast
Director
Special Projects
Stormont–Vail Health Services Corporation
Topeka, Kansas

Major Comments

The incentives available to rural communities that have been harnessed to maintain adequate health systems have been diminished. Are residents of rural areas faced with the option of remaining, with a lack of necessary health care, or moving to population centers where medical services are easily accessible?

The purposes of community health centers:

- provide health care to rural residents who are isolated from other services;
- provide basic medical services without regard to the ability to pay;
- provide a full range of primary care services and referral systems to secondary and tertiary levels of care.

Factors that are currently affecting health care include:

- farm foreclosures, high unemployment, loss of insurance;
- young people leaving rural communities to go where the money is (leaving a community with a very high level of elderly residents, many of whom are poor);
- declining tax bases of rural counties and rural hospital districts (rural hospitals are closing their doors at a faster rate than urban hospitals).

Although one quarter of all Americans live in rural areas, the per capita expenditures for health and related services are far lower for rural residents.

Recommendations

Develop systemic and regional solutions based on the cooperative efforts of elderly consumers, health-care providers, health-care payors and the community.

Prepare and support the elderly in the change of health-care delivery methods.

Establish a systems approach to reconnect service delivery between urban and rural areas. This is vital to preserve health-care delivery in rural areas.

Because every community is different, those who plan rural programs must start at the local level to determine what is needed and to define the process. Those at the local level must "carry the ball" to achieve long-lasting change.

Get community business leaders involved. A good primary health-care system is an important component in community development efforts and helps keep people in the community.

It is often necessary to work with adjoining communities in developing a basic health-care system, because any system requires a certain population base to assure its continuity and survival.

Because the ball game changes weekly, you have to keep up.

Strategies and Developments in Delivery of Rural Long-Term Care

Moderator *Betsy Palmer*
Executive Director
Nebraska Department on Aging
Lincoln, Nebraska

Presenters *Dr. Linda Redford*
University of Kansas Medical Center
Kansas City, Kansas

Dennis Loose
Executive Director
South Central Nebraska Area Agency on Aging
Kearney, Nebraska

Ruth Von Behren
ON LOK Senior Health Services
San Francisco, California

Major Comments

Creative approaches to the delivery of long-term care services are being developed for rural areas around the country. Public and private resources are being expended to develop viable systems.

The Kearney Care Management Program

The Kearney Care Management program was started in 1982 as a demonstration program and has served 1100 people since that time. The client load is 20–22 people per month.

The Kearney Care Management Unit, which has served as a model for the statewide system just being implemented, uses a registered nurse as the care management coordinator. This facilitates dialogue with physicians, whose support is critical to make the system work.

Care management clients in the South Central Nebraska AAA pay for in-home services they need, as determined by an initial assessment and periodic follow-up. The AAA care management specialist works within the service area to identify groups and individuals capable of supplying the necessary mix of in-home services to assist a frail older person in his or her daily living.

This statewide system patterned on the South Central Nebraska AAA care management program will use a common assessment tool developed by Dr. Linda Redford. The document will be used by both the Nebraska Department on Aging and the Nebraska Department of Social Services as it administers the Medicaid Waiver applied for in connection with this service. Commonality of assessment is desirable but, because no two communities are alike, the system must be flexible.

ON LOK

This program, designed to meet the needs of the frail elderly over 55, began as a model day care project in San Francisco in the early 1970s. *On lok* is a Chinese phrase which means happy, peaceful abode.

Currently, there are about 300 persons in the ON LOK program.

Clients often have as many as five illnesses. They are provided transportation to one of three day care centers, where plans of care are developed which are broad in scope. These can range from music participation and recreation to access to health services.

Care plans are reviewed by specialists, including a physician, a therapist, nurses, social workers, paraprofessionals, drivers, etc. The role of the physician is a key portion of the total care package. This multidisciplinary approach is the heart of its unique approach to health assessment and treatment.

ON LOK's success is due to its pooling of funds and services. The care provided is 20 percent less than nursing home care. Administrative costs are low because the facilities are community based.

ON LOK charges a capitated payment per month, which allows greater flexibility than a fee for service arrangement. The fee covers any health or supportive service offered by the facility.

Funding for clients comes through Medicare/Medicaid and private pay. The client agrees on the cost and that is all. ON LOK accepts the risks if costs increase.

ON LOK—Working Principles

1) *Focus on the frail.* While in principle comprehensive, coordinated services should be available to *everyone*, in practice the model must start with the high-cost population: the very impaired and frail requiring ongoing care for the rest of their lives.

2) *Comprehensive services.* Medical, restorative, social and supportive services must be effectively integrated if a program is to effectively respond to the multiple and interrelated problems of a long-term care population.

3) *Coordinated response*. All services must be effectively integrated to respond to the needs of the client in the most effective and efficient manner.

4) *Service control*. The service team has the capability and authority to readily access, preferably provide, any and all services required by its impaired client population.

5) *Community emphasis*. While it is unrealistic to think all the needs could be met in community settings—hospitals and nursing homes are part of any comprehensive package—participants' continued residence in the community is emphasized along with the community's ongoing participation in the program.

6) *Risk-management orientation*. The organization must be able and willing to assume financial risk, that is, possess the management skills and information base to effectively monitor clients, services and costs and readily adapt to changing situations to increase the efficiency and effectiveness of the service system.

7) *Flexibility*. Medicare and Medicaid waivers allow the provision of appropriate services at the appropriate time without customary restrictions.

The ON LOK model can be adapted to rural communities by:

- building on the resources and strengths of rural communities;
- thinking about NEEDS—bend procedures, rules and regulations, and laws to allow needs to be met in innovative and cost-effective ways;
- flexibility—establish system principles, goals and objectives; allows rural communities to determine how they will be met; expect variety;
- consolidating service response, delivery and funds; give providers positive incentives to use resources appropriately and efficiently.

Other Comments

Family problems often enter into an assessment. There is a need to know the degree of frailty of an older person and determine the dangers and risks of independent living for that individual. An assessment needs to be made of the family situation and a determination made as to whether the family is being realistic about the client's needs.

After a patient is discharged, planners are no longer involved in the plan of care of their patient, and families often are in need of a realistic assessment of the older person in their care.

A care manager needs to be able to coordinate services. Several kinds of help may be needed, such as homemaker and personal care, and may be needed at different times of the day. Someone needs to oversee and monitor a plan of care. That person will need to know how to get services, monitor them and determine if they are cost effective. Many agencies that provide services are self-serving.

The comprehensive functional assessment is a critical component of effective case management. Such an assessment provides the information necessary to accurately, and in a comprehensive manner, identify the client's needs and resources and to effectively address those needs. Further, aggregate data from functional assessments provide an objective and valuable resource for program planning.

The importance of comparable databases at the local, state and national levels is clearly apparent. Scarce resources and a growing segment of the population requiring these resources mean that tough decisions must be made on the allocation of existing resources and the commitment of monies to the development and expansion of services. Data are needed for such decisions to be made in an equitable and effective manner. Personal and programmatic biases must be resolved or set aside to assure the development and growth of comprehensive data systems.

In a standardized assessment, objectivity is essential. The document must take a holistic approach to a client's needs:

- What are the daily living capabilities?
- Is there evidence of depression?
- What is the level of the client's capabilities?
- Is the housing adequate?

A care management program must insure that all clients are being assessed within the same parameters.

Assessments provide a database that can determine needs on a county-by-county basis. This database will help decision makers determine where services are needed. There may be inequities among various counties, but assessments will help us make educated decisions regarding needs.

We will be witnessing the development of "hub" communities because long-term care cannot be provided in every small town.

While advantageous, a full range of supportive services does not have to be developed prior to a care management system's being developed.

People are leaving the hospital sooner and sicker today. Their families cannot objectively identify what types of services will be required.

Because of the variety of services offered and the complexities of accessing these services, coordination of services is needed.

There is a lack of reliable data on the needs of the elderly. The needs of the people who are elderly today are different from what the needs of the people who are forty today will be in the future. We must set forth programs today which are flexible enough to meet the needs of future cohorts. We cannot start over as people and needs change.

Recommendations

Although no one system will work in every area, there are sufficient systems operating, and the best parts of these systems should be looked at to understand those elements that make them work.

Case management programs should not be controlled by or provided by agencies with a vested interest.

A good working relationship needs to be developed between the program, the medical community and other service providing agencies.

Case management coordination is important. An interdisciplinary approach, using the skills of an RN, a social worker and a physician, is recommended for each person needing care. This team, or the coordinator or case manager, can then meet with the family and others to develop a care plan.

Supporting Rural Caregivers

Moderator — *Lloyd Kennedy*
Executive Director
Northwest Arkansas Area Agency on Aging
Harrison, Arkansas

Presenters — *Dr. Burton Halpert*
Associate Director
Center on Aging
University of Missouri, Kansas City
Kansas City, Missouri

Becky Thompson
Program Analyst
East Arkansas Area Agency on Aging
Jonesboro, Arkansas

Major Comments

Family and friends still provide most of the care to older persons in rural areas. Older persons themselves are frequently the caregiver for a spouse or perhaps for an older developmentally disabled child.

Rural hospitals, caught by both Medicare changes and the farm crisis, now comprise more than 50% of all hospital closures in the U.S.

Patients are being released from hospitals at an earlier stage in the recovery process. Persons with chronic conditions are often not admitted to hospitals.

Family caregivers lack the technical competence and emotional preparedness to deal with the early discharged or chronically ill adult.

Family caregivers lack knowledge of patient rights under Medicare.

Doctors in rural areas frequently have little or no knowledge of services available to the elderly and disabled.

Information was provided on the Volunteer Information Provider Program, which was initiated in rural counties in Missouri and has since been replicated in twenty-three other states.

Process:

- survey organizations with credibility in a community and determine if members are willing to do volunteer work on behalf of the elderly;
- an Administration on Aging grant provided funding for the development of materials and a manual that could be used to train volunteers who, in turn, could then train others.

Recommendations

Identify organizations and individuals in each community who can assist in the planning process.

Help caregivers make plans for developmentally disabled dependents to provide for their physical and emotional care, to determine what resources are available to support them, and to determine where they will live.

A resources directory is needed for each community and should be placed in each agency.

Interagency cooperation is needed.

Education about services for the aging is needed for physicians and for hospital social workers.

Use town meetings and information fairs to publicize services that are available for the elderly.

Keep legislators informed about problems and programs for the elderly.

***Plan*—know your population and determine their needs.**

Change policies to allow for equity of payments to rural hospitals under Medicare instead of the current inequitable rural/urban differential.

Increase the number of health-care professionals in rural areas.

Increase communication between rural and urban facilities to ensure that older adults and their caregivers will be supported following an older adult's stay at an urban treatment center.

Empower caregivers to work in partnership with the formal system.

Harnessing the Entrepreneurial Spirit in Rural Communities

Moderator — *Dr. Ronald L. Harper*
Strategic Management Development Services, Inc.
Shawnee Mission, Kansas

Presenters — *Shawn McKenzie*
Area Manager, Economic Development
Southwestern Bell Telephone
St. Louis, Missouri

Barbara Puls
National Conference of State Legislatures
Denver, Colorado

Glenn Davis
District Director
Small Business Administration
Kansas City, Missouri

Major Comments

Economic development issues are at the center of problems and possible solutions to the continued independence of rural Americans. In today's world, unfortunately, we are not seeing the word *entrepreneur* being used in the connection of rural interests, rural needs or rural hopes, dreams or aspirations.

Aging agencies should get a copy of the economic development plan for their state and incorporate elders in the plan.

More than 80% of the care of elders is provided by family members and friends. Economic development helps keep the people who provide this care in the community.

Three types of assistance:

- training and technical assistance programs;
- financial assistance;
- personal support.

Three ways to do economic development:

- attract new industry;
- retain and expand existing industry;
- create new industry.

Steps for economic development:

- organize resources;
- analyze needs of the area;
- create a plan of action;
- implement plans;
- evaluate progress.

A healthy economy in a rural area helps older people in the area by helping ensure that stores stay open and doctors stay in the community.

Southwestern Bell has material to help small businesses and incubator programs get started in rural areas.

The role of the federal government in the solution of problems of this country is shrinking, despite the increasing number of bureaucrats and the increasing federal budget.

Government can only provide leads and open doors. Government cannot create entrepreneurs. Neither can government turn rural Kansas back to the simpler way of life, the idyllic life of Gray's "Elegy Written in a Country Churchyard"—"Far from the madding crowd's ignoble strife."

The next decade will be a renascent small business community in a world of floundering megacorporations, a farm world dominated by commercial agribusiness. Agriculturally, it has been that way in Kansas for many years, but we have not been willing to admit it. New jobs in Kansas' future are going to be provided by small businesses and large farms.

In a graying population, with a widening gap in the number of women compared to men, the number of women going into business will probably be the most significant factor of the next decade. Women-owned businesses are now 33 percent of the total, increasing at a rate of 9.4 percent a year, compared to a 4.3 percent increase per year for men-owned businesses.

Malpractice laws must change. Product liability legislation must be enacted. Long-term care and catastrophic health legislation must be passed. Mental health insurance must be as reliable and available as physical health insurance.

By 2030, some 21 percent of our population will be 65 or older, and two-thirds of our workforce will be from minority groups. Sadly, 50 percent of our educable youth

will not be prepared for the workplace. That is why McDonald's and other companies are hiring older workers. There really are not enough young men and women to go around, and some of them are not able to read the menus or decipher the needs of customers.

Tomorrow's major industries are going to be health care, health-care services, eating and drinking establishments—industries heavily dominated by a female work force, and in the urban areas, a minority female work force.

Economic Opportunity Loans are available at SBA offices for businesses located in high unemployment areas or owned by low-income individuals.

Rural populations in general tend to have a high rate of entrepreneurial activity, and the extensive experience accumulated throughout a lifetime of employment and life experiences can greatly enhance the probability of success by rural elderly entrepreneurs.

"Transfer Payment Investment" programs, which are based on the concept that dependent populations need new options for escaping dependence and attaining self sufficiency, have been successfully used in many European countries and in the Third World.

Self employment through transfer payment investments offers the potential to provide employment to out-of-work individuals through entrepreneurship as well as the possibility that the new small businesses may grow and provide employment to additional workers.

A transfer payment investment policy that supports self employment can contribute to two important goals:

- employment training and education;
- job generation.

Transfer payment investment is already in use in a number of programs across the United States. Primarily this method has been applied to on-the-job training programs whereby the employer provides training to a transfer payment recipient in exchange for receiving a payment for part of the costs of employing and training the participant.

The development of self-employment and entrepreneurial training programs through the use of transfer payment investment offers a great deal of potential to increase the recipients' human capital. Through developing their own businesses, they gain skills and make business contacts. Thus, even if one individual's business fails, the person has increased his or her chances of gaining unsubsidized employment.

The **WEDCO** Program

The Woman's Economic Development Corporation in St. Paul, Minnesota, is a private nonprofit venture that targets unemployed and underemployed women who want to start their own businesses. The program offers the individual everything from personal counseling to business plan development, financial assistance and follow-up support groups. Of WEDCO's clients, some 24% receive some form of transfer payment.

With WEDCO's assistance, 564 women have started new businesses and an additional 300 have expanded their businesses. Of the businesses WEDCO helps start, approximately one-third employ people in addition to the owner. In 1985, job generation averaged three fulltime jobs and five part-time jobs per business assisted.

In addition to WEDCO, several other programs have been implemented, including Maryland's Equity Participation Investment Program (EPIP). Under this program, financial assistance is provided to low-income people who wish to open a franchise. The rationale for promoting franchise development is that franchises are a part of an already established business with an established clientele, the parent corporation provides technical assistance to new franchisees and usually provides financial assistance in the form of necessary equipment.

EPIP can invest up to 45% or $100,000 of the initial investment needed by the franchisee. The individual must provide 10% of the initial investment. In return for the financial assistance, the state seeks preferred stock in the franchise and thus earns a return in the form of a royalty. The state seeks to recover its investment in five years. The administrating authority has stated that each $10,000 in equity investment by the state creates one job.

In designing a self-employment program for the low income and unemployed, the importance of a comprehensive approach cannot be overstressed. Beginning entrepreneurs, especially those who are dependent on transfer payments, will require technical assistance, financial assistance and personal support if they are to succeed in their efforts to gain self sufficiency.

Meeting the Health Needs of the Rural Elderly

Moderator — *Betty Grandquist*
Executive Director
Iowa Department of Elder Affairs
Des Moines, Iowa

Presenters — *Russ Profitt*
Executive Director
Heritage Area Agency on Aging
Cedar Rapids, Iowa

Dr. Kitty Buckwalter
Abbe Center for Community Mental Health
Cedar Rapids, Iowa

Major Comments

Older persons are chronically underserved in their receipt of mental health services. However, special problems have been identified and solutions have been developed to improve service delivery in rural areas.

Rural elderly do not go to psychologists or psychiatrists. Yet many elderly have mental health needs that are going untreated.

An important issue to consider is the elderly who are caring for their dependent children.

Certain assumptions have been made:

1) Mental health centers are not adequately serving the elderly. Their client loads are under 6% elderly; the percentages for rural elderly are even lower.

2) Area agencies are not focused, equipped or funded to work with the mental health needs of the rural elderly. It is estimated that 7.4 million Americans will be affected with dementia by the year 2040.

The growing needs for long-term care require an analysis of local, state and federal policies and funding.

Funding wars must be anticipated between programs for the mentally ill and for the elderly. However, this "trend needs to be bent"; we need to work together so that no one is injured by the competition for dollars.

MR, DD, and MI costs have escalated.

A question—Whose responsibility is it to provide long-term care for MR, DD, MI and elderly?

Barriers to mental health funding for the elderly include:

- our ignorance of funding sources;
- the elderly themselves, who don't want it;
- policy makers who live by crisis planning.

Rural residents have a high risk of mental illness. Other problems include:

- depressed economy;
- limited medical and social resources;
- correctable illness and sensory problems, which often go untreated or undetected;
- resistance to accepting mental health services;
- organizational barriers, including the Medicare cap;
- poor pay for social workers, nurses and psychologists;
- lack of essential special training in geriatrics for many social workers, nurses, physicians and psychologists;
- bureaucratic impediments.

Recommendations

To remove the barriers to mental health funding for the elderly:

- whenever possible, join forces and programs;
- avoid funding squabbles;
- form a coalition of associations and advisory groups;
- educate the elderly and others who will be helped;
- establish innovative health services delivery systems, such as outreach models that take needed services to the elderly most in need of them—those who would not self-refer;
- develop community-based identification sources (e.g., gatekeepers, case management, on-site screening) to identify the mentally ill elderly in need of services;
- develop a true *continuum* of services for preventive counseling, acute (crisis) care and long-term community based options.

Community Colleges and Universities as Part of the Solution to Rural Problems

Moderator *Dr. Suzan Schafer*
Dean, Continuing Studies
Pittsburg State University
Pittsburg, Kansas

Presenters *Joyce Hartmann*
Executive Director
Western Kansas Community Services Consortium
Pratt, Kansas

Dr. Leo Cram
Cooperative Extension Services
University of Missouri
Columbia, Missouri

Dr. George Peters
Center on Aging
Kansas State University
Manhattan, Kansas

Major Comments

If the trend is to be bent, it will have to be shaped by local people, and people will need subject-matter support, new ideas, and back-up informational resources for helping them introduce positive change into their respective communities.

Colleges and universities are repositories of knowledge and information, and their role in society is to:

- generate new knowledge through research;
- share this knowledge through teaching and training;
- perform a public service role by helping individuals and community groups engage in community development activities.

Community colleges and universities are a major resource that may be used by rural communities in creating positive change. Academic institutions generally recognize a responsibility to the community, but often a lack of knowledge of the rural community obstructs potential progress.

Community colleges represent the presence of higher education in rural areas. They can play a vital role in educating care providers and a wide variety of other professionals, paraprofessionals and community leaders associated with the aging network.

There is a long tradition of building gerontology programs at the university level; however, the results of these program developments have not been put into practice on the grass roots level.

Kansas State University is now working with seventeen community colleges in four states to develop gerontological linkages between community colleges and universities.

Kansas State University is working with medical schools in Kansas and Missouri and with vo-tech schools to provide training for care providers.

The University of Missouri has developed two adult care centers as community services and for education of students, particularly in nursing and the social sciences.

Extension service personnel can help develop leadership skills for lay leaders through seminars.

We have only begun to tap the potential of our older Kansans. It is unlikely that massive resources in the form of person-power or funds will be reallocated to rural areas.

The Western Kansas Community Services Consortium (WKCSC) was incorporated as a nonprofit agency in 1971. Its current membership consists of deans of continuing education at nine institutions, and its service area includes 73 counties and 71% of the state's geographic area. The Consortium began its aging projects in 1983 with a grant from the Administration on Aging and as partners in a grant to Kansas State University from the Fund for Improvement of Post Secondary Education to develop gerontological curricula.

College programs are not just for kids anymore; they are for lifelong learning, for professional training, for enrichment, and for economic development. Economic development and aging are inseparable; programs that assist economic development make jobs, which keep young people home "down on the farm." Because family caregivers make up 80% of the caregiving population, it is important to government and social service agencies to keep families together.

Community Colleges offer a number of services that involve the elderly:

- Intensive health care instruction is provided for nurse aides, nurses, nursing home staff members and administrators; much of the instruction has gerontology content;

- Many credit and noncredit workshops and educational programs are provided to older citizens and caregiving families;
- Fulltime faculty gerontologists are employed at several colleges;
- In an Entrepreneur-in-Residence program, a Silver Haired Legislator shares his business knowledge and experience with students;
- Older walkers exercise in the halls during winter months;
- Retired Senior Volunteer Programs (RSVP) are sponsored;
- Recreational opportunities are provided on campuses, and at least one serves as a daily mealsite;
- Experienced older adults frequently serve on college advisory boards.

Colby Community College sponsors an RSVP program and employs a gerontologist on its fulltime faculty. Bingo games, dances and other recreation are sponsored on campus for older students. Many other community colleges have active and ongoing programs.

Recommendations

Closer working relationships must be established between universities, colleges and community colleges and aging agencies.

We need to provide more avenues for educational interaction with retired persons, appreciating and using their increased acumen, wisdom, judgment, and problem-solving abilities.

Kansas community colleges and universities must have greater encouragement and financial support in their role as adult educators.

Aging-related service providers should learn about the resources that institutions of higher education possess. Resources include:

- faculty—academic subject-matter knowledge; research knowledge and skills; teaching and training competencies; and community development practice skills;
- secondary data—databases and information that can be used in a variety of settings, e.g., data for updating the annual plan for an Area Agency on Aging.
- facilities and services—staff and facilities for conducting conferences and meetings; sophisticated equipment for enhancing effective communications, e.g., audio/visual; satellite television.

Aging-related service providers should become familiar with the organizational structure for the particular college or university and locate appropriate points of access into the institution.

In working with colleges and universities, one must be cautious about inviting them to participate in direct service activities. The role of the college or university is to generate and disseminate new knowledge and not become involved in direct service programs, which are the role and responsibility of private enterprise, public agencies, and not-for-profit organizations. However, colleges and universities often serve as effective catalysts or provide incubators for programs.

(Note: A somewhat different view has been given.)

Even the university must present "old" knowledge in its basic classes. The community college responds to the educational needs of its community and provides needed services, often as brokers for education in outreach centers in rural areas. The university is research oriented, but the community college is pragmatic, filling in educational gaps within its "catchment area." For the community college, research is secondary to services.

Provide opportunities for college or university faculty members and administrators to:

- render a public service to the community, e.g., provide training and consultation for employees of aging-related service providers;
- serve on boards of directors, task forces, and ad hoc planning committees;
- pursue basic and applied research projects.

Invite faculty and administrators to develop and test adult day care centers. New strategies for creating adult day care centers must be developed for rural areas—i.e., down-scaling a relatively large comprehensive adult day care center that serves 35–40 senior citizens and creating smaller entities that serve 2–3 people.

Use the primary volunteers and clients of colleges and universities in productive gerontology work. For example, members of the county extension home demonstrations could be invited to undertake special public service projects that provide minimum in-home care services for frail elderly people or undertake an information and referral process for elderly people.
4-H club leaders and youth could be invited to engage in intergenerational projects with the rural elderly.

Universities and community colleges must overcome any distrusts and learn to work together by using their respective strengths.

Meeting the Needs for Rural Housing

Moderator *Frances A. Squyres*
Kansas Department of Commerce
Topeka, Kansas

Presenters *Tom Tjepkema*
Tjepkema and Associates
Duluth, Minnesota

Dr. Joyce Mercier
Iowa State University
Ames, Iowa

Major Comments

Elderly people are generally satisfied with their current housing and have relatively little interest in housing alternatives.

Few elderly have made definite plans for a time when they might have to move.

Congregate housing is the fastest growing need in rural areas.

Recent tax law changes and the reduction of subsidies make the development of congregate housing very difficult.

Congregate housing requires different management skills from conventional housing management.

Aesthetics are important, especially in comparison with any existing subsidized housing in the community.

The need for congregate housing exists; the demand has to be created.

Recommendations

Greater efforts must be made to educate the elderly and their children about available housing alternatives.

To have a successful congregate housing project:

- know your market and how to market to it;
- seek multiple, broad-based funding;

- develop cooperative relations with public and charitable bodies to enhance acceptance of the project;
- keep costs for housing and services as reasonable as possible;
- seek management with service delivery experience, not just housing management experience.

Educational programs need to be implemented to convince people that congregate housing is not "low-income" housing.

Volunteerism as a Resource to Rural Communities

Moderators

John McDonald
ACTION
Kansas City, Missouri

Jim Byrnes
ACTION
Topeka, Kansas

Presenters

Winnie Robb
OEDA Area Agency on Aging
Beaver, Oklahoma

Jolene Niernberger
Senior Companion Program
Fort Hays State University
Hays, Kansas

Susan Robinson
RSVP Director
St. Joseph, Missouri

Cindy Davis
Director
EODD Area Agency on Aging
Muskogee, Oklahoma

Major Comments

The high cost of services in rural areas necessitates the extensive use of volunteers to provide those services. A major question: Will the quality of services be high if volunteers are used extensively?

Issues to be resolved:

- recruiting volunteers;
- keeping good active volunteers;
- overcoming the shortage of male volunteers;
- developing new programs in which to use volunteers;
- obtaining adequate funding for volunteer programs.

The fears and concerns of the dependent elderly include:

- loss of independence;
- health concerns;
- transportation problems;
- loneliness.

Citizen involvement is one of the most cherished American traditions.

A nursing home or long-term care facility should not be a place to die, but a place to live. With good volunteers, that is exactly what a nursing home or a long-term care facility will be. There must be active, positive involvement by volunteers.

People have long searched for the key that unlocks the secret of aging. One of these secrets is to become involved with ...

Volunteering

We continue to grow and develop throughout life. Judgment, experience and creativity do further unfold with time.

Because of their experiences, retired persons are vital resources: they can share with others the talents and skills of a lifetime.

In rural communities, volunteer programs are often a way to introduce many elderly people to the resources available to them and to acquaint them with the aging network.

Recommendations

Develop strategies to encourage young people to get in the habit of volunteering. However, this is difficult, because they are busy with their work and other activities.

We need to encourage senior adults to use their valuable experiences as volunteers in their communities and educate the general public to accept their services.

To maintain active volunteers:

- provide good training;
- provide adequate support for them;
- show appreciation by giving positive feedback;
- provide leadership opportunities for volunteers.

A Presentation on the **SENIOR COMPANION** program:

- The Senior Companion is a person who

  - meets income guidelines (federal poverty level);
  - wants a small stipend to supplement income;
  - is willing to work with an older person 20 hours per week @ $2.20 per hour;
  - is at least sixty years of age;
  - is capable of commitment to a relationship;
  - can share strengths, experiences and skills.

- The client is a person who

  - has a need;
  - is willing to permit a companion to share skills.

The program is mutually beneficial for volunteers and clients. For the client:

- ability to maintain independence;
- low or no cost personal attention and care;
- new friendships and companionship.

For the Senior Companion:

- stipend;
- increased self esteem, pride, sense of accomplishment.

A presentation on the **RSVP** program:

Two goals:

- to provide 60+ people with the opportunity to remain active and share their talents and abilities;
- to help those with problems and to extend and support the services of service organizations.

As much as possible, screening is done to match a volunteer with a client.

Founded in 1971, the program has grown and now provides 70 million hours of service per year, with 375,000 volunteers and nearly 750 projects nationwide.

Benefits for participants:

- free accident and liability insurance for enrollees;
- opportunities within volunteers' areas of abilities;

- free transportation or reimbursement of transportation expenses;
- recognition to volunteers.

The RSVP program does not allow for a stipend; therefore, the "Older Volunteer Service Bank" concept may be explored to provide motivation to prospective volunteers.

Currently, in St. Joseph, Missouri, a Respite Care Program (volunteer-based with more than 30 volunteers) is a successful pilot project for the banking-of-hours concept and is supported by the state of Missouri. Simply stated, a volunteer donating hours of service may receive like services in the future in hours equal to the number of hours "banked." This concept could easily be expanded to other areas of volunteerism. Transportation, a primary barrier to senior persons, could be an example. The "transportation disadvantaged" make up approximately 28% of the population. Many of these persons are seniors isolated in rural areas. Through the "banking" concept the states could help initiate a much-needed volunteer-based transportation network to persons in rural areas.

Rural Minorities in the Midwest

Moderator *Dr. Arnold Parks*
Lincoln University
Jefferson City, Missouri

Presenters *Dr. Ellena Bastida*
Wichita State University
Wichita, Kansas

Dr. Brenda Crawley
Gerontology Center
University of Kansas
Lawrence, Kansas

Major Comments

In both rural and urban settings, the problems of older persons are generally magnified among those who have had to suffer discriminatory practices and attitudes.

We tend to blame the victim as an explanation of why minorities do not seek services. Examples:

- they don't like us;
- it isn't part of their tradition;
- their families take care of them.

Major characteristics of elderly Hispanics:

- fewer numbers; lower concentration;
- not as well educated;
- not natives of Kansas;
- poor;
- migrant workers who worked for low wages and have no social security;
- do not own land or machinery;
- large families—7 or 8 children;
- greater incidence of chronic illnesses because of inadequate health care;
- lower life expectancy;
- victims of prejudice;
- exodus of minority youth to areas where economic opportunities are greater.

Most rural black elderly persons reside in the southern United States.

Myths about minorities include:

- they are not used to formal services;
- they would rather stay home;

(Note: This is not true in areas with higher concentrations of minorities.)

- their families will take care of them;

(Note: If majority families find this difficult, why assume that minority families do not have the same problems?)

- they do not come in for services.

(Note: Service providers have divorced themselves from minority groups.)

Other issues:

- language barriers—bilingual providers are needed;
- councils and boards have become inbred; many people serve for ten or more years.

Carol Fraser Fisk
U.S. Commissioner on Aging
Administration on Aging
Department of Health and Human Services
Washington, D.C.

Note: The following statement by Commissioner Fisk expands on many points that she made in her address at the concluding luncheon of the conference.

I hardly need to tell you that concern about aging is now everywhere. The issues of older people are discussed in the news, portrayed in TV programs, catered to in special magazines and appealed to with more and more discounts and special services. Recently Congress has expanded its discussion of aging issues and I trust our presidential candidates will do so also. More and more groups and organizations want to serve older people and benefit from them. That's why your involvement and leadership are of vital importance.

The demographics of our changing society are startling. You know them just as well as I do. Today 1 in 9 Americans is an older American. By the year 2030 that number will have jumped to 1 in 4, or 25% of Americans will be older Americans. This vast demographic change means that every segment of our society will be influenced by the larger number of older people living in our country. This vast change also means that every community will need to adjust to respond to the talents and the needs of its older citizens.

I would like to suggest to you that what really matters to us as we age is the community environment where we are. The character of the place where we live, shop, worship and even work will make the difference in the quality of our later years.

Depending on where you are in our great nation, **COMMUNITY** may mean different things. It may mean the city where you live. It may mean a total county. For others of us, our community may be a smaller unit, such as a rural neighborhood. Whatever the unit and its name, the place that matters to each of us is the area where we live and carry out our daily activities—where we shop, visit the doctor, worship and meet with friends.

For each of us that area should be a good place to live and mature. Our community should offer options for us as we age, no matter what our interests, abilities and resources. Our community should be a favorable environment for aging independently and with dignity in ways that will give each person's life meaning and quality.

I suggest to you that a community that is a good place to grow old should have 10 elements. These 10 elements describe steps that each community should take in reviewing and improving the quality of life for its older citizens. These 10 points aren't startling ideas, but I do believe that they provide a framework for action anywhere in our nation.

1. Does your community have a **visible point of contact** where anyone can go or call for help, information or referral on any aging issue?
2. Does this point of contact lead to a **range of options** including jobs, volunteer opportunities, suitable housing, good institutional care, nutrition, transportation, health and other needed services?
3. Is this range of options **accessible** to all older persons—the independent, semi-independent and totally dependent, no matter what their income?
4. Are **all resources**—public, private, voluntary and personal—committed to supporting the system of options for older people?
5. Does **collaborative decision-making** between public, private, voluntary, religious and fraternal organizations and older people exist in your community? Are all those concerned with older people working together in your community?
6. Is there **special help or targeted resources** for the most vulnerable older people, those most in danger of losing their independence?
7. Is there **good referral** from agency to agency to assure that information or assistance is received, no matter how or where contact is made in the community?
8. Is the system in your community **flexible** enough to respond with appropriate individualized assistance, especially for the vulnerable older person?
9. Is your response to the aging of our nation tailored to the **unique** nature of your community?
10. Is there **leadership** in your community to convene all interested persons, assess needs, design solutions, train personnel, track overall success, stimulate change and plan community response today and in the future?

Of course, the question that we must now ask ourselves and each other is **HOW DO WE MAKE THIS A REALITY?**

Each of us has a special role to play in making every community in our nation a good place to live and to mature. As service providers, you play a special role. So do the state units on aging throughout the nation and their AAAs. AoA has a role to play, as do local, state and national elected officials. Profit making groups and organizations, voluntary groups, public agencies, units of state government, religious organizations, medical providers, hospitals, families and especially older people themselves—all must contribute to this national effort.

For service providers such as you, the challenges are many and varied. The pressures are great, too, as you work to respond to those challenges on a daily basis.

First, you are called on to provide service that is highly effective and increasingly efficient while it is also compassionate and timely. That sounds easy, but with costs and demand rising, I know that is not always the case.

Second, as service providers, you are pressed by your clients and your own sense of commitment to reach out to help service recipients in a way that goes well beyond your own scope of service. You must refer them to other agencies for other services that they need and often work extensively with families, near and far, who are worried about their older loved ones.

Next, you are constantly worried about funding. It is one of the harsh realities of your work. You must develop funding through contributions from participants and also obtain support from other sources of government, foundations, and local groups. Money is always on the mind of a service provider.

You are also called upon to collect data and to provide feedback to the AAA and to others on activities and unmet needs. I am sure that sometimes the paperwork for these obligations must seem overwhelming, though you know the importance it has for program improvements and possible expanded funding.

It is the obligation of those of us who work with you to help make your job easier. The Administration on Aging, the state unit and the Area Agency on Aging should be working in ways that help you meet your responsibilities to older people and complete your many daily tasks with greater success.

The work of the Administration on Aging should help you do your job better and easier. I hope that it is the case. AoA's efforts to influence others in the federal government and to exercise some horizontal leadership should be working in a way that you feel tangible benefits.

Let me give you an example of how I hope this has happened. We in AoA have worked hard in our efforts to influence the Public Health Service (PHS). We have joined with PHS thus far in two specific program areas intended to benefit older Americans: 1) health promotion and 2) building links between aging programs and the many community health centers funded by PHS throughout the nation.

In the area of health promotion, since 1984 AoA has worked with PHS to establish state coalitions on health promotion and to develop specific written materials and programs for older people in the area of health promotion. I hope that you have received and used the health promotion materials we have developed and shared with the state agencies and area agencies. I hope that the state coalitions have reached out to you and encouraged and rewarded program changes that emphasize health promotion among older people through your service programs.

Similarly, we have worked hard with the Public Health Service to build bridges between local aging program providers and the PHS Community Health Centers. We have had a series of regional and state meetings aimed at exchanging information and then linking the two programs more effectively. I hope this has helped you gain better access to those Community Health Centers for the older people you serve.

There are other things that AoA does which should result in benefits for you and the work that you do as service providers. We use our discretionary resources to fund research, education, demonstrations and training. Then we disseminate the results of those projects to the state units and the area agencies. I hope that you find those materials helpful and that you learn from them instead of reinventing the wheel when problems come your way. I hope, too, that the special training we have funded as demonstration projects has benefitted some of you.

AoA also refers many older people and their families to the AAAs for linkage to you. I hope that is an effective referral. We also work hard to develop opportunities for joint funding and programs at the service delivery level. For example, our current joint effort with the Robert Wood Johnson Foundation and the Alzheimer's Disease and Related Disorders Association was specifically intended to help those of you who provide day programs further develop your capacity to collaborate with ADRDA and better serve the victims of Alzheimer's disease.

The work of the state unit on aging should also enhance your ability to do your job successfully. State units exercise a similar kind of horizontal leadership, only at the state level. Those efforts should be visible to you and should help in your daily work. For example, AoA funded the National Association of State Housing Finance Agencies to work together in selected states to build links between state housing and state aging programs. I hope you have seen positive results of that effort in your service areas.

The state unit on aging also sets policy and provides guidance appropriate for statewide aging activities. I trust that also reinforces and supports your role in meeting the needs of older people.

In a like manner, the area agency in your area should also help you do your job better and with greater ease. As the convenor and catalyst for all groups and organizations in the planning and service areas, the AAA brings the players together and can greatly facilitate coordination, help providers avoid duplication and assist in generating funds for the services you provide. The AAA can also help assure that the information you have on service needs and community resources as a result of your service experience is included in the planning process and in decisions about future resource allocation. The AAA should help build local community support, understanding and commitment to your role in serving older people.

The recent reauthorization of the Older Americans Act reaffirmed the responsibilities of AoA, state agencies, and area agencies to assure that community systems serving older people are strengthened throughout the nation. The act underscores the special roles that we all play, as outlined in my examples above. In reauthorization, Congress also reaffirmed the need for strong partnerships and for effective coordination on behalf of older people. Their action underscored concern for the most vulnerable elderly by emphasizing the need for more outreach and referral. AoA was also mandated to report to Congress in greater detail on the nation's accomplishments on behalf of elders. The new law also reemphasized the need to use service funds most wisely.

The draft regulations echo all of the Congressional actions. AoA is very proud of the proposed regulations. They are timely, which gives us a sense of accomplishment. They also are well organized and reflect the partnership among AoA, state units, AAAs and service providers. Most importantly, I believe that the proposed regulations are responsive to the new interest throughout our nation in the talents and needs of older Americans.

As you might expect, we have numerous comments on the proposed regulations—about 700 comments. We received comments from congressmen and senators, state agencies, area agencies, service providers and older persons.

Comments focused on many issues. We received advice and suggestions on:

- the availability of program development funds;
- AAA designation, organization, staffing and placement;
- new mission statements for state agencies and AAAs;
- definition;
- legal assistance;
- ombudsman;
- advisory council roles;
- services to native Americans;
- contributions;
- data collection;
- confidentiality of information about service recipients;
- internal AoA organization issues.

We are considering all these observations and plan to respond to as many as we can. The changes we make will be to respond to issues that address the successful implementation of the program. We will, however, not stray from the mission of the act and the mandate it contains to build strong state and community systems for older Americans today and in the future.

I believe that the Older Americans Act provides the framework for our national response to both the *talents* and the *needs* of all of us as we age—today and tomorrow. As you know, the debate on that response is heating up. Each day

brings a new chapter, new players, new options and I hope, ultimately, new clarity of issues.

I hope that the debate will continue to be broadened to recognize, as you do, that a range of high-quality support services of all kinds, not just high-quality health care, is essential to all of us as we age. I hope policy makers will continue to consider ways to reinforce family and other informal networks, not replace them. And I most fervently pray that final decisions and resulting programs will assure that growing old expands our choices, our dignity and our independence, no matter what our income, status, educational background, family structure or geographic location in this nation.

I urge you to join in this debate. We in AoA will continue to do all we can to stimulate informed and compassionate discussion that helps address the needs of elders and services to them in proper relation to the contributions that older Americans have made and will continue to make to our society.

I urge you also to continue to work to assure that your community builds a strong system that responds to all older people today and prepares for the future.

If decisions are made at the national level, at the state level, in the private sector or in an individual family that result in new resources to respond to older people, you must be confident that the foundation is there to make best use of these resources. How your community measures up today is critical. How will it respond tomorrow?

The challenges and opportunities for all of us who work with and for older people are tremendous. You have very special obligations and responsibilities in the lives of millions of older people. We in AoA are impressed by your success and creativity in meeting those obligations. We commend you for your fine work and, of course, encourage you to do more. You have our pledge of collaboration and support and our sincere thanks. We look forward to continuing to work with you.

Appendix A

Conference Co-Sponsors

Organizations

ACTION
American Association of Retired Persons
Mid-America Congress on Aging
Council of State Governments
National Association of Counties
State Units on Aging and State Associations of Area Agencies on Aging:
Arkansas, Iowa, Kansas, Missouri, Nebraska, and Oklahoma
NCOA/National Center on Rural Aging

Members of Congress

Arkansas
U.S. Representative Bill Alexander
U.S. Representative John Hammerschmidt

Kansas
U.S. Senator Bob Dole
U.S. Senator Nancy Kassebaum
U.S. Representative Dan Glickman
U.S. Representative Jan Meyers
U.S. Representative Pat Roberts
U.S. Representative Jim Slattery
U.S. Representative Bob Whittaker

Oklahoma
U.S. Representative Mickey Edwards
U.S. Representative Bill Clay
U.S. Representative Glenn English
U.S. Representative James Inhofe
U.S. Representative Dave McCurdy
U.S. Representative Mike Synar
U.S. Representative Wes Watkins

Iowa
U.S. Senator Tom Harkin
U.S. Representative Fred Grandy
U.S. Representative James Leach
U.S. Representative James Lightfoot
U.S. Representative Tom Tauke

Nebraska
U.S. Senator Jim Exon
U.S. Senator David Karnes
U.S. Representative Doug Bereuter
U.S. Representative Hal Daub
U.S. Representative Virginia Smith

Missouri
U.S. Senator Kit Bond
U.S. Senator John Danforth
U.S. Representative Tom Coleman
U.S. Representative Bill Emerson
U.S. Representative Ike Skelton
U.S. Representative Gene Taylor
U.S. Representative Harold Volkmer
U.S. Representative Alan Wheat

Appendix B

Conference Planning Committee Members

Many thanks to the following people for their hard work and dedication to making this conference a success.

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PART II

SELECT COMMITTEE ON AGING FIELD HEARING

SELECT COMMITTEE ON AGING

FIELD HEARING

Pittsburg, Kansas
June 13, 1988

Statement of the Honorable Jan Meyers, U.S. Representative, Third District, Kansas

One of the most urgent needs facing Kansas and the nation is rural health care. As a Kansan, a Member of the House Select Committee on Aging, and as a concerned citizen, it is a privilege to be here today to address this vital issue. It is especially appropriate to be talking about rural health care in Pittsburg, Kansas rather than in Washington, D.C. It seems more fitting.

I think it is fair to say that there is a heightened awareness in Congress of the problems associated with rural health care—transportation, availability of services, costs, Medicare reimbursement rates, and availability of doctors and nurses.

As many of you know, the week of May 15 was declared "National Rural Health Awareness Week." The resolution states that:

- Rural Americans account for nearly 25% of the population, but are served by only 12% of the nation's doctors, 18% of the nation's nurses, and 14% of the nation's pharmacies;
- The resulting health status of rural Americans remains significantly lower than that of urban Americans, with rural Americans showing a disproportionately higher rate of maternal and infant mortality, injury, and chronic illness;
- Accessibility to the available health care services in rural America is limited not only by the lack of transportation, but also by the fact that more rural residents are uninsured;
- Closures of rural hospitals and other health care facilities, which have a severe impact on their communities, continue to spread across the rural areas of our nation.

Furthermore, several important provisions were included in the Budget Reconciliation Bill for Fiscal Year 1988. First, the bill authorized grants to assist small rural hospitals and their communities in the planning and implementation of projects to modify the type and extent of services the hospitals provide in order to adjust to various changes. This planning could involve changes in service population, clinical practice patterns, demand for acute-care inpatient hospital capacity, ability to provide appropriate staffing for inpatient hospitals, demand for

ambulatory and emergency services, and demand for appropriate integration of community health services. The President recommended funding for this program in FY'89; the Appropriations Subcommittee on Health has yet to report its recommendations. We should know what this recommendation is in a few

The Reconciliation Bill created an office of Rural Health Policy within the Department of Health and Human Services. Its charge is to coordinate all rural health care issues and be a voice for further reforms and innovative approaches. It should be a real advocate for rural America.

A physician in a rural health care manpower shortage area will get an additional 5% repayment in addition to the Medicare repayment. It also increased the reimbursement for rural health clinics from $32.19 per visit maximum to $46.00. Furthermore, psychologists' services in rural mental health clinics are made reimbursable, and direct reimbursement is authorized for psychologists' services furnished at community mental health centers.

Another important provision requires Peer Review Organizations to take into account special problems associated with delivering care in remote rural areas, the availability of alternatives to hospitalization, and the distance from a patient's residence to the site of care. These are important steps, but the efforts must continue.

Testimony of Monda Spool, Director, North Central-Flint Hills Area Agency on Aging, Manhattan, Kansas

The North-Central-Flint Hills Area Agency on Aging services an 18-county community comprised of approximately 54,000 persons 60 years of age or older. These individuals live in varying degrees of independence—from total independence with the ability to perform adequately daily living tasks to total dependency, unable to perform even the simplest of daily living tasks. The aged population is dispersed throughout a predominantly rural geographic region comprising approximately 20% of the state's land area.

Access to services for these rural residents is affected by the primary factors of: 1) means to access, i.e., transportation; 2) knowledge to access; and 3) service network available to meet the need. Types of services available to the rural elderly vary in the degree of sophistication provided and in the frequency of service availability. As an example, medical facilities housed in Salina service adjoining counties where such facilities are not available. The physical facility location limits the frequency of services available to the surrounding communities.

The North Central-Flint Hills Area Agency on Aging directly provides nutrition, community services, employment, and "Keynotes," a regional newspaper to the community. The agency contracts on the local level to purchase in-home services, accessing services, and to support senior facilities. Mental health, income maintenance, medical and housing services are typical types of local services available in a rural area.

Linkages between and among service providers thus become a crucial element for the effective and efficient delivery of adequate services.

Problems which arise as elders seek assistance vary from inadequate services existing on the local level to lack of knowledge for identifying sources of help. Coordination difficulties also add to the problem. Sheer geographic distance to service providers' facilities also contributes to difficulties associated with receiving needed services. Lastly, the additional unit cost increases in a rural setting by virtue of geography, numbers served in sparsely populated regions and overall operational service delivery costs.

Formal/Informal service providers exist in varying degrees throughout a rural region. Oftentimes, there is a genuine lack of formal service providers to meet the multiple needs of the aged. Where formal structure exists, multiple service functions fall to a single organization out of necessity to provide this help. Due to costs and limited availability of resources the multiple-function organization can more adequately address service needs. These rural organizations, through pooling of resources, professional talent, and cost sharing, can provide an adequate level of community services.

The Area Agency has used innovative linkage solutions. The North Central-Flint Hills Area Agency on Aging uses 41 nutritional sites as focal community access points. This network enables elders at the community level access to assistance. In addition, the Community Services for Aging program (CSA), a direct service program sponsored by the Area Agency, provides service linkage through a core group of 115 volunteers. The volunteer network provides assistance to older persons attempting to access services. These volunteers directly link the older person to the helping professional, serve as peer counselors, and perform outreach activities to expand community knowledge of available services. The regional newspaper published by the Area Agency, which reaches approximately 17,500 elderly persons, is another technique to improve service accessibility. Readers are provided with current information on services available and on how to access these services.

During the period from October 1, 1987 to April 30, 1988, 887 CSA participants sought service linkage. The types of requests received were categorized into aging services, public benefits, consumer, nursing home, legal and miscellaneous. Twenty-two percent were requests for transportation, 25 percent were requests for energy assistance, and 41 percent were requests for insurance assistance, i.e., filing for benefits. The CSA program is but one method existing at the local community level to aid rural residents to access programs and services. CSA interfaces on a regular and frequent basis with local providers to coordinate assistance provided to the elderly population.

The RURAL ACCESS project is another example of a cooperative effort among the North Central-Flint Hills Area Agency on Aging and fifteen other agencies, hospitals, nursing homes, etc., in Riley County. The seventeen month project focuses on developing a computerized directory of pertinent services for the county's elderly citizens and in disseminating information concerning the directory to the elderly through various outreach activities.

Accessing the directory may be accomplished easily, with one phone call; however, public awareness of the directory will require other outreach efforts. Aside from publicity, the project includes the gatekeeper program where community service people may learn about the directory and disseminate that information to their clients. Participating agencies in the grant may also pass along news of the directory through their involvement in caregiver training provided by the grant, through agency newsletters and other word-of-mouth activities.

The directory itself incorporates a comprehensive listing of services for the elderly, ranging from those provided by formally organized agencies to informal services provided by volunteers or other individuals. The directory will provide a one-stop way for the elderly and their families/caregivers to obtain information on services currently available to the elderly. The directory will also contain valuable information on many services previously known only to a limited number of human service staff. Computerizing this type of information is contingent on each agency's willingness to contribute toward a cause which will not only help the

elderly live more independent lives, but will also assist agencies in more effectively meeting the needs of the elderly in our county.

Successfully building the entire system requires participation, support, and a common understanding of the project's goals from all agencies involved. Early in the project, the Project Coordinator met with each agency's administrator and project representatives to review the project, foster a sense of teamwork, and stress the mutual benefits each agency will receive from the project. Since then, the Project Coordinator and the Project Director have met monthly with the subcontractors of the grant, followed by monthly meetings among all participating agencies.

To facilitate a cooperative spirit, agencies have been encouraged to join in group decision making on various aspects of the grant. Although at times this has delayed completion of a few data related components of the grant, it has also increased agencies' interest in the project and a desire to "see it through." The project often addresses certain matters of "turf" and, therefore, it is extremely important that agencies are given the opportunity to express their interests and participate in the decision making process. It is hoped at the completion of this project that a computerized information and referral accessing tool will be in place.

Glen Elder Work Connection serves as an example of service linkages to meet in-home needs for handyman and chore services. Job seekers participating in this low-cost new program provide information on skills and work experience. Mowing, window cleaning, cooking, driving and grocery shopping services are provided by these workers. Available workers are listed on a Senior Center bulletin board and monthly newsletter. The center staff links the senior to the worker. The six month budget to fund this service was $900.00. The program was coordinated with other services being provided by center personnel, which reduced the costs for the Work Connection Program.

Conclusion

The needs of rural elders do not vary from those of their urban counterparts. The methods used to link and coordinate aging services in a rural community are as diverse as the types of communities which exist across rural Kansas. Coordination, effective linkage systems, and cost containment are the components necessary to build those systems which serve the old.

Testimony of Karen Olson, President, Combinations, Inc., St. Louis, Missouri

Combinations, Inc. is a company that provides shared housing alternatives for companionship or financial and personal assistance, which is based on compatibility matching. It also offers pre-evaluated rental referrals and caretaker services for vacant homes awaiting sale.

The housing problem of the aged is enormous:

- In 1985, the elderly numbered 28 million (12% of the United States population);
- Since 1900, life expectancy in the United States has increased 30 years (males, 71; females, 78);
- In 1985, 30% (8.1 million) of all non-institutionalized older persons lived alone;
- When people retire, they do not typically move. Older people prefer to make adjustments within the home they already occupy or at least stay in their local environment.

(Leo Baldwin, Coordinator, Housing Programs, AARP)

A clear picture emerges: the need is enormous; the elderly need to be aware of all their housing options; alternative housing programs should exist that will help them remain in their homes or at least continue to actively live in their home communities; and the community should be prepared to assist in housing transitions.

Combinations, Inc. provides four divisions that service the housing needs of the elderly in a variety of ways. Since opening in 1984, it has served over 4000 older and younger applicants with an overall 95% success rate.

Combinations meets the great need for interim housing among the elderly, who may not be ready for institutional housing. We procure conveniently sized and equipped apartments or houses or homesharing companions to provide for income and/or companionship and services. For people moving to smaller quarters, we provide caretaker services for their vacant home until it is sold.

Homesharing helps to fulfill the 3-part recipe for elderly happiness: good health, economic security, and viable companionship. It lessens loneliness and anxiety and provides built-in friendship. There are several homesharing options. Two elderly people may share only household expenses and chores. An elderly person needing more attention may have his/her needs met by a homesharer who pre-agrees to the assistance to be given, from cooking and cleaning to errands, transportation, or non-professional care for the disabled. The sharer may receive rent-free accommodation or a small allowance. The sharer becomes a part of the household, not an employee.

Combinations' homesharing processing includes:

- Compatibility screening of both parties to a match, including personal interviews to discover likes, dislikes, interests, attitudes, and needs. References are checked; credit checks are made. Compatibility screening requires considerable experience and expertise to provide candidates suitable to a range of situations. It is the key element to the success of a match.

- Writing and inserting line advertising in local publications, handling all correspondence, and maintaining confidentiality.

- Coordinating all contacts and appointments between applicants.

- Providing a 30-day trial period, during which the match is tested. Should any irresolvable problems occur, the search is reinstituted at no extra cost.

As Combinations, Inc. has operated out of one urban location, our service has been geographically limited to urban and suburban needs. But four years of experience with Seniors has helped us to identify, adapt to, and cater to the needs of the elderly in general, providing us knowledge and skills that can be extended to the needs of the rural elderly as well.

Problems Specific to Rural Elderly

1) Medical. The burden on one person (elderly spouse or child) caring for an elderly person can be very taxing. There is often a need for neighbors to monitor the elderly. Medical services are limited or distant. Transportation to medical facilities is difficult. County assistance with medical expenses may leave the elderly to pay for extra costs and equipment rental. Nurse-initiated hygiene may be infrequent and irregular.

2) Transportation. The elderly person who does not drive is very confined and dependent on others. Both shopping and recreation are curtailed. Even those who drive may be housebound by inclement weather.

3) Home maintenance. The elderly find it hard to keep up with home and yard chores. Power cuts may be paralyzing. Amenities may be limited, e.g., possession of only a wood-burning stove that may be too much for one person to keep going.

4) Nutrition and self-maintenance. Often the elderly neglect or are unskilled in the preparation of regular meals. Knowledge of good nutrition may be lacking. Clothing may be neglected, both as to repair and cleanliness.

5) Companionship and recreation. The need for company may be only sporadically met. For the most part, social organizations exist in town. Access to recreation (movies, library, senior center, etc.) may be limited by distance or inability to travel.

6) Rental options. Often in rural areas, rental apartments are not nearly as available as in the city. If the elderly cannot continue to handle their own home alone, alternative housing options are fewer than for the city dweller.

7) Control. The elderly often feel a loss of the power to control their own lives (a loss often heightened in a nursing home), and they need encouragement to go on caring for themselves and staying active. Reliance on neighbors and outside friends becomes an imposition. Self-reliance needs to be continually reaffirmed and housing situations must be developed to encourage it.

We offer several suggestions to meet the housing needs of the rural elderly:

A. **Homesharing**

One of the most important keys to solving the elderly's housing problems is single or multiple homesharing. The benefits are obvious: companionship, greater security, lower expenses, and someone there if you need them. It also reduces the financial burden on the State.

The key to homesharing is the matching of people together and a homesharing referral program to accomplish this requires the following components:

1) It must be affordable. Combinations charges a fee of $73.00 that barely covers the cost of processing and has still had to turn away hundreds that could not afford that minimal fee. A sliding scale would make the program accessible to triple the current volume of applicants.

2) Services must be available to everyone. To meet the rural need we propose a referral service with the following features:

- One main metropolitan office that handles local applicants, data storage, and matching processes.
- Satellite offices that have one or two counselors whose responsibilities are to interview applicants and handle the local part of the search. All applicant information is then transferred to the main computer system for storage and retrieval. Since the matching of candidates is a highly skilled endeavor, the central counselors will do this in consultation with the local interviewer. There are two advantages to this system. No local community is wholly dependent on its own local resources, but the familiarity of the

local counselors with their community will be fed into the central processing.

- A strong network with social workers and medical professionals.

B. **Retirement Counseling**

There need to be more encompassing retirement counseling programs—not just company sponsored programs, but public programs available to the employed and also to the spouses and to the non-employed. The programs that exist now typically address the financial concerns of the elderly. We need programs that are concerned with the human elements: What if I have a stroke? What if my spouse dies—will I be able to maintain my home? What are my options?

C. **Comparative Study of Programs for Elderly**

An exploratory study of successful programs established in other countries is valuable. Two examples are:

1) The cooperative home. In England seniors are sharing large older homes with 8 or more residents. Each person has his/her own room and assists with household and yard chores. An employed house manager oversees the operation. Each resident pays rent, a portion of the utilities, and for food. In the United States, many smaller communities have large older homes which might be converted into cooperatives to allow rural residents to remain in their general environment. For this type of situation a referral service is almost essential to create a compatible group.

2) The collective village. Collective villages are used throughout Europe. Collectives are small, informal, semi-planned community developments in rural settings within a specific geographical area designed for the retired elderly of that area. This allows residents to continue to participate in their social structure: church, grange, etc. The one-story single family units are built to appeal to older owners with the emphasis on ease of maintenance and ease of activity. These units are situated on at least an acre of land each to allow continued gardening, etc., and to give a sense of space that rural residents are accustomed to. Yard care assistance can be provided on request. Homes can be purchased or rented (the rented units being owned by the collective). Occupants are usually required to pay a small monthly maintenance fee. Since these collectives are less formal than the usual retirement village, fewer restrictions are generally specified. The residents are the decision-making body as to how the collective will function. Some possible options for them are: an employed resident manager; a club house with or without activities; a van to facilitate transportation; and a small convenience store.

D. **Trial Programs**

All over the United States various experiments in alternative housing for the elderly are being tried. We need more shared information on these experiments. As is true in other areas, so in housing, programs should be field-tested for quality and effectiveness. More of these tests should be initiated now before the problems of the rural elderly reach a crisis level. By instituting pilot programs with smaller numbers of persons, we can see how well they work and expand them as necessary to meet the increased population of rural senior Americans, who are asking—How and where do I live out my final years? Each project should have a clear system of accountability and assessment built in.
Existing options include:

Independent living:

- Continue to live in own home;
- Buy smaller home or condominium;
- Rent a house, condominium or apartment;
- Mobile home;
- Resort community.

Semi-independent living:

- Homesharing;
- Living in one's own home and hiring part-time nursing or homemaking professionals;
- Living in one's own home and attending day care centers or day hospitals;
- Living in a retirement community with or without health and custodial services;
- Living in an apartment hotel;
- Living in low income and public rental housing;
- Living in retirement apartment houses;
- Living in retirement hotels;
- Living in a licensed boarding house where elderly live in protected situations and receive help with daily care given by non-medical staff;
- Living with relatives.

Dependent living:

- Retirement home with health and custodial services;
- Licensed board and care homes with professional nursing care;
- Intermediate care nursing institutions;
- Skilled nursing care institutions;
- Hospital;
- Hospice.

E. Guiding Philosophy

"People come first in every situation." This is the guiding client-oriented philosophy at Combinations, Inc. In designing programs it is easily lost to other concerns, but we need to constantly remind ourselves of it. The system must be responsive to the users and adapted to their needs. Too often the elderly have been dealt with, with a view to our needs rather than theirs. Available options are not always desirable because moving the elderly from their familiar setting can be a shock that leads to earlier deterioration.

Testimony of Ronald W. Beane, Administrator, Operations Division, Iowa Department of Elder Affairs, Des Moines, Iowa

As advocates for elders in a predominantly rural state, we know that almost every service designed to encourage independence among rural elders is dependent on the availability of accessible, affordable transportation. I also am the Chairman of the Transportation Accounting Consortium, a group of eight states (Arkansas, Colorado, Florida, Iowa, Massachusetts, Michigan, North Carolina and South Carolina) formed nine years ago to identify and reduce barriers to coordinated transportation, especially in rural areas.

As with many other states, many Iowa seniors are living in rural areas, separated from essential medical, social and shopping services. More than sixty percent of Iowa counties have populations of less than 20,000. Over fifteen percent of the counties have no town with a population over 2,500. This means that some of the vital services must be obtained in another county. With Iowa's rapidly growing population over 85 years of age, it is clear that an increasing proportion of our citizens are prevented from driving either for financial or health reasons.

Fifteen years ago, state agencies in Iowa identified that coordinated transportation systems would provide the most cost effective service delivery to the widest range of constituent groups. For very good reasons, funding is available from a number of different sources with local decision making regarding implementation. We believe that the best coordination occurs at the local level, with state and federal agencies enabling local coordination through capacity building and thoughtful review of requirements for records and reports.

Several aspects of administrative capacity building are being addressed by the Transportation Accounting Consortium, with financial support from the U.S. Department of Health and Human Services and the U.S. Department of Transportation. The Consortium has issued *Rural Transportation Accounting: A Model Uniform Accounting System for Rural and Specialized Transportation Providers*. This manual promotes good accounting practices for transportation providers which allows multi-funded systems to meet the financial reporting needs of human service agencies purchasing rides. Now the Consortium is developing a training package to assist state and local agencies implement the recommendations. We are ready to help the Rural Technical Assistance Program develop cost allocation and financial management procedures which will further increase the capacity of rural transportation providers to efficiently meet the special needs of a variety of constituents.

In 1986, the U.S. Department of Transportation and U.S. Department of Health and Human Services established the Joint Council on Interagency Transportation Coordination to improve management practices, remove federal barriers to coordination, and disseminate information. Additional Congressional support of these efforts would be particularly helpful at this time. Rural transportation now

receives more support from states than from the federal government. Federal applications can be optimized by increasing flexibility to encourage local coordination.

Thank you for your concerns for rural elders who depend on your support of transportation to prevent isolation in their own homes.

Testimony of Debbie Ford, M.S.W., Social Rehabilitation Consultant, Beverly Enterprises, Hot Springs, Arkansas

Note: On August 15, 1988, Ms. Ford began employment with Saint Josephs Hospital in Hot Springs.

My employer, Beverly Enterprises, is the largest long-term care organization in America. Our company operates approximately 1050 nursing homes throughout the United States.

A few years ago, while working in a facility in North Arkansas, an elderly woman approached me and said, "I'm so lonely, I'm so lonely I could die. My husband died several years ago and now I'm all alone. No one seems to care." Such is the plight of many of our rural elderly in the United States today. I left this woman with a renewed commitment of researching and promoting a way of successfully meeting the social and emotional needs of others like her.

The United States Census Bureau projects that the 75-plus and 85-plus age groups are the fastest growing segments of the U.S. population. These groups represent 40% of the nursing home residents in the United States. In this area of the United States, the rural elderly represent a vast majority of the nursing home population. It has been estimated that the 85-plus population will more than double in number between 1980 and 2000.

With the increase in the number of rural elderly in this society who are entering nursing homes, the helping professional is faced with the task of identifying innovative ways of meeting the mental health needs of this rapidly growing population.

In our industrialized society, nursing homes are and will continue to be essential in providing needed care to the frail elderly. Under even the best of circumstances, placement in a nursing home is traumatic and can result in overwhelming fears and anxieties. Losses that accompany old age and institutionalization can contribute to feelings of helplessness and hopelessness. Depression, isolation, feelings of helplessness and other emotional problems significantly affect the quality of life for the nursing home resident.

Group work is an effective way of meeting the social and emotional needs of the elderly. Our company has recognized the importance of promoting consistent group work within our nursing homes. As a result, each full-time social service director is required to have a minimum of four social service groups.

The objectives of group work include: promoting socialization, ventilation of negative feelings, developing support systems, enhancing self-esteem and turning focus from self. As one psychologist notes, "Human beings cannot stand alone. The

group is not just one aspect of human life, but it is lifeblood itself, because it represents belonging to humanity."

There are several group approaches that can be used. Examples include reminiscence groups, reality orientation groups, problem solving groups, and new resident adjustment groups. The group that seems to be most successful with the rural elderly is reminiscence. This group is based on "life review," a concept developed by Robert Butler.

According to this concept, the process of life review begins as early as age ten and increases in frequency with age. The older person facing the reality of impending death attempts to put past, present, and future life in perspective by reviewing past life experiences. Reminiscence serves as a deterrent to unpleasant present life circumstances. The rural elderly, having common interests such as farming, gardening, canning, etc., use the group as a means of communication, thereby assisting them in developing relationships.

Problem solving groups give residents the opportunity to share problems and concerns. Reality orientation groups are useful for those experiencing a mild to moderate degree of confusion. Reality orientation is one treatment method that can be used to revitalize the senses and to promote an awareness of surroundings. Involving newly admitted residents in an adjustment group is one method that can be used to combat fears concerning admission to a nursing home. New resident adjustment groups provide an opportunity for new residents to develop relationships within the nursing home and to ventilate fears concerning the home.

By involving the nursing home resident with a group of peers who are experiencing similar problems, the elderly person comes to the realization that he is not alone. His life experiences are shared by other members of the group. We must rely on the strength available to us through peer counseling in a structured group.

With the predicted increase in this population, society needs to continue developing health care professionals in order to meet the social and emotional needs of each resident on an individual basis. Multiple mental health concerns such as isolation, loneliness, lack of socialization, and depression can be addressed in a series of forty-five minute group sessions.

Group work with nursing home residents requires a unique set of skills and techniques. Many characteristics of this population make it difficult to conduct successful group sessions. In order to be successful, the leader must have a clear understanding of the special characteristics of this population, as well as group processes and techniques. Educating group leaders is essential in promoting quality group work. Resources must be made available through state and federal agencies. Funds are desperately needed to provide for the social and emotional needs of the institutionalized elderly as well as the rural elderly living in their homes.

Group work, used in combination with other treatment programs, has the potential for significantly improving life in the nursing home. Examples of other available programs include direct service intervention, one-to-one counseling, volunteer programs, the adopt-a-grandparent program, and the activity program.

Over the past ten years, I have witnessed an increased awareness in the nursing home industry in meeting the psychosocial and emotional needs of residents. However, we must continue as a country to strive to meet those needs. This can only be accomplished through dedication, perseverance, and a genuine concern for the mental health needs of the elderly.

Testimony of Patrick H. Donahue, Coordinator of Senior Citizens Law Projects, Kansas Legal Services, Inc., Topeka, Kansas

Kansas Legal Services provides legal advice and representation to persons over the age of 60 on a statewide basis and contracts with all 11 Kansas Area Agencies on Aging to provide legal services to senior citizens under the provisions of the Older Americans Act.

In 1987 our non-profit law firm provided assistance to 4,232 Kansans over the age of 60. We prioritize our services to those seniors in the greatest social and economic need. These are low-income, homebound, handicapped, isolated minority and institutionalized individuals. We routinely work in support of the Kansas Nursing Home Ombudsman's office, and we interface with all social service agencies.

I personally represent senior citizen clients every day. From 1984 to 1987 I served as Chairman of the Kansas Bar Association Committee on Legal Issues Affecting the Elderly. I was asked by the Kansas Legislature to provide technical testimony during the development of Kansas' new Division of Assets law, and I have testified on other matters affecting older persons, consumers of all ages, and children.

The senior citizens' cases we typically handle include:

- Low-income wills, probate and estate plans, powers of attorney, and living wills;
- Guardianships and conservatorships;
- Pensions, Social Security and other retirement income;
- Medicare, Medicaid and private health care;
- Housing;
- Consumer, finance, insurance;
- Adult abuse;
- Nursing home matters.

General Facts about Seniors in Kansas

In 1986 the revised 1980 Census estimated that 17.9% (441,000) of all Kansas residents are over 60. Kansas is tied with New York and Maine for twelfth place in the 50 states. The over 60 and over 65 growth rates are 7.0% and 7.7% respectively, compared to only 4.1% for our population at large. A report prepared for the Kansas Department on Aging in December 1986 reveals that 33% of the population in Elk County was over the age of 60. There are 8 out of our 105 counties with more than 30% of the population over the age of 60. In 22 of our 105 counties, more than one person in ten is over the age of 75.

There are more elderly poor than young poor. The 1980 Census showed that 49,472 or 12% of 412,297 Kansans over 60 were below the poverty line. On a statewide basis

10.1% of the population was below the poverty line. The largest concentration of senior poverty is found in the Southeast and in the non-urban Northeast parts of Kansas where over 15% of the persons aged 60 and over are poor.

The senior population is predominantly female, with 7 women for every 5 men in the 60+ population. About 52% of the persons 75 and older live alone. In the 60+ group, 56% of the women and only 15% of the men live alone. About 4.1% of the elderly population in Kansas can be considered minorities. According to data collected by the Kansas Department on Aging, about 2/3 of the Kansas elderly population can be considered as living in rural areas.

Economic Problems Affecting the Rural Residents of Kansas

In Kansas today, we have a population of 2,450,000, of which approximately 1,200,000 live in rural areas. Kansas citizens living in these areas face a number of economic problems:

- Lack of employment opportunities due to shifting of local retail markets in communities of under 10,000 to centralized retail distribution centers in larger communities.
- Declining employment opportunities due to the declining fortunes of agriculture and energy industries.
- Out-migration of younger residents who can't afford to stay, leaving behind persons with pension and retirement incomes.
- Loss of potential employees and markets which undermines the start-up or expansion of traditional small businesses.

Evidence of these conditions is easy to find. Banks in rural Kansas continue to fail. There were 8 failures in 1987 and 5 to date in 1988. The Kansas State University Cooperative Extension Service October 1, 1986 Data Source Book on *Kansas Demographics* points out that there was a tremendous out-migration as a part of a national trend in the 1960s. But between 1970 and 1980 Kansas still had out-migration (-0.9%), while other rural areas were recovering. Most of rural western Kansas is still enduring population losses.

Population replenishment does occur, but when it occurs it is in urban, not rural areas. The *Salina Journal* of May 8, 1988 noted:

"Farm income declined rapidly between 1979–1985 Average income in the last 5 years was $10,401 (per family), far short of the almost $18,000 needed to cover family living expenses, much less make payments on debt, taxes or purchase machinery."

Despite moderate increases in rural property values in the past year, Kansas land prices remain at approximately 50% of their 1981 values. This net loss of asset value produces corresponding reductions in property tax revenues and this, in

turn, makes it increasingly difficult for smaller communities to finance the infrastructure improvement essential to encouraging business expansion. Residents, young and old alike who remain in the smaller rural communities, may benefit from lower housing costs, but their expenses for durable goods and for a great many services which respond to national, not local, price signals are often higher due to transportation and distribution surcharges.

While I believe that we are heading toward significant improvements in most rural areas, much damage has been done. The young can and do move elsewhere in search of better opportunity. It is the older persons who stay behind.

Remedial Action

I was asked to comment on my views of remedial action. First, let me say that I am no expert in rural economics, sociology, community development or macroeconomic planning. But common sense tells me that there is a solution. I think the following ingredients are needed:

- Stabilization. People in rural areas are able to work with what they have if they can figure out what that will be. Changing federal programs and regulations interrupt sound local planning, e.g.: The loss of federal revenue sharing dollars has occurred at a very bad time for struggling communities.

- Support. Outside help where help is needed, and only where help is needed. Help should target crucial areas like health care, transportation, in-home services, educational and technical support.

- Community Involvement. Communities, given breathing room, can create local economic development which fits the nature of the community and utilizes existing community tangible and intangible resources.

- Local Investment in Local Business. Invest local support in local projects. This is the best insurance of success. It puts the return and the risk in the same place.

A. 1987 Public Broadcasting System documentary, *Little Towns Like These*, showed examples of smaller communities that have been successful in protecting themselves against the "ghost town" threat. Three communities were showcased: Red Cloud, Nebraska; Jefferson, Iowa; and Oberlin, Kansas. Oberlin is a northwestern Kansas community (pop. 2,387) where local investments by local businessmen working through an economic development group of the local Chamber of Commerce started two successful businesses—a boat manufacturing company and a bus company.

Needs of the Rural Elderly

In my experience, the needs of the older urban population and the needs of the older rural population are the same. However, it is more difficult and expensive to construct and maintain systems for the rural elderly than for their counterparts living in urban areas. In 1965 when Congress adopted the Older Americans Act, it identified our national objectives with respect to the needs for our elderly population.

The Congress hereby finds and declares that, in keeping with the traditional American concept of the inherent dignity of the individual in our democratic society, the older people of our Nation are entitled to, and it is the joint and several duty and responsibility of the governments of the United States and of the several States and their political subdivisions to assist our older people to secure equal opportunity to the full and free enjoyment of the following objectives:

1. An adequate income in retirement in accordance with the American standard of living.
2. The best possible physical and mental health which science can make available and without regard to economic status.
3. Suitable housing, independently selected, designed and located with reference to special needs and available costs which older citizens can afford.
4. Full restorative services for those who require institutional care.
5. Opportunity for employment with no discriminatory personnel practices because of age.
6. Retirement in health, honor, dignity—after years of contribution to the economy.
7. Pursuit of meaningful activity within the widest range of civic, cultural, and recreational opportunities.
8. Efficient community services, including access to low-cost transportation, which provide social assistance in a coordinated manner and which are readily available when needed.
9. Immediate benefit from proven research knowledge which can sustain and improve health and happiness.
10. Freedom, independence, and the free exercise of individual initiative in planning and managing their own lives.

The Older Americans Act of 1965

42 USCA Sect. 3001

The Older Americans Act also establishes legal assistance for the elderly as a priority service. I am part of that legal assistance system.

I do not believe that the 1965 objectives of the Older Americans Act or the needs that gave rise to them have changed. What has changed is our understanding of what is required to meet those needs and our view of the appropriate methodologies for best meeting those needs. By way of example, consider how our view on the subject of long term care has changed from promoting the construction of new nursing homes to devising comprehensive support systems designed to keep people in their own homes.

General Needs of Seniors

There are three mutually supporting components which all of us need to survive with dignity. These are good health, adequate life-sustaining resources and a spiritually satisfying purpose for life. When any one of these elements is removed, continued existence is threatened. Older persons face high risk of expensive deterioration of health and have little opportunity to increase their incomes. For those of us concerned with the well-being of seniors, it becomes essential to promote health care and to insure that seniors have adequate life-sustaining resources.

Among the older rural Kansans I work with, I believe that the following are the most important needs:

- Access to adequate affordable health care;
- Protection from family impoverishment due to catastrophic illness;
- Adequate long-term custodial care;
- Protection from family impoverishment due to long-term care;
- Safe and sufficient housing;
- Effective and efficient transportation;
- Alternatives to loneliness;
- Comprehensive in-home services for those who can almost do everything for themselves;
- Assistance in retirement planning and in dealing with the bureaucracies that provide support;
- Protection from abuse;
- Timely and caring substitute decision making for those who can no longer make decisions for themselves;
- Nutrition services for the needy, shut-ins and those who are unable to provide for themselves;
- Employment for those who can and want to work.

Meeting these needs costs money. Dollars spent must show measurable results or those who provide the dollars will grow reluctant to contribute and turn a blind eye on the need. Government policy should, in my view, set minimum standards and allow for local implementation. There is no reason why it should be easier for a senior in one rural county to get a ride to a doctor than in another rural county.

There should be no reason why a senior in one county can easily get legal representation and another living elsewhere can't.

Catastrophic and Long-Term Care Support

The 1987 session of the Kansas Legislature took a bold step in passing Senate Bill 264, The Division of Assets Law. This timely legislation makes it possible for people who need nursing home care to receive Medicaid assistance while they set aside a portion of the family income and life savings for their spouse to live on. This law took effect on May 1, 1988. In the first 30 days 97 families signed up. Of these 90 had a spouse already in a nursing home.

Other states which have adopted similar measures include Minnesota, California, Washington, Idaho, New Mexico and Illinois. We are hopeful that the Federal Medicaid officials (HCFA) will not reject our new law. We take heart from the recent (June 8, 1988) passage of the Medicare Catastrophic Coverage Act of 1988 (H.R. 2470). This landmark piece of legislation will provide substantial relief to many who badly need it.

The federal law contains provisions permitting Medicaid eligibility and for protecting spouses from impoverishment for long-term care. The provisions of the federal law are very similar to the Kansas Division of Assets Law. We note, however, that the "division of assets" provisions of the new federal law will not take effect until September 30, 1989. For some seniors, that day is a long way off.

Let me conclude by asking this question: What do you think your mother and father should have in their old age? Then let me ask whether anyone else's mother and father should be entitled to less?

Testimony of Joan Remmers, RN, Sabetha, Kansas, founder of the Nemaha County Home Health Agency and past President of the Kansas Association of Home Health Agencies.

Our elderly are the fastest growing segment of our population. The need to develop a comprehensive plan to meet the rapidly growing needs must remain an urgent priority. We must continue to search for cost-effective quality services. In my opinion, that can best start with long-term in-home care. We must plan strategy that includes families, neighbors, churches, civic groups and professional providers to direct, coordinate and provide these services. In many, if not in most instances, it is less costly to provide for these needs in the home, rather than in a nursing home or hospital.

I want to share with you a case history of a 97 year old female our agency provided care for. She lives alone on her family farm. She has poor circulation and osteoarthritis. She was paying $8.50 for one hour each week of home health-aide service to assist her with bathing. One day, the home health aide noticed a large blister on her left leg. The aide notified her long-term care nurse, who came to evaluate her condition.

She was taken to her physician, and treatment was initiated. The RN made daily visits to clean and evaluate the site and apply medication and dressings for two weeks. This part of her care was paid for by Medicare. After the ulceration was healed, she resumed private pay service for bathing.

Soon her mobility and confidence was improved, and the aide was dismissed from service. Within a short time she was admitted to the hospital with recurrent blisters and cellulitis. The blisters had been present for approximately two weeks before she sought medical attention. The end result was ten days in the hospital with intravenous antibiotics, whirlpool treatments and leg ulcer care. That was followed by twice daily care by the home health agency following her discharge from the hospital.

She then consented to resume weekly aide services for bathing and evaluation of her skin conditions. Blisters did reoccur several times, but treatment was initiated and she was spared hospitalization. By paying $8.50 per week out-of-pocket, she probably saved Medicare many thousands of dollars. When it comes to paying for long-term preventive or maintenance care, she was more the exception than the rule. Most would try to "get by" rather than pay for services.

According to the U.S. Bureau of the Census, one out of seven Americans age 65 and over live in poverty. An even greater percent live near poverty. If they are financially strapped, how can we expect them to pay for care that they can't conceive will prevent or delay institutionalization. Our state and federal government must look at their savings of health care collars. Home and Community Based Services (HCBS) is the closest move in the right direction that I have seen. HCBS is a combination state and federal program. The recipient of this

service must be financially eligible for Medicaid assistance and must be medically eligible as determined by an SRS social worker and an RN.

The following is an example of how that program does and does not work. A female, approximately 80 years old, was admitted to a nursing home by her children, who lived a considerable distance away from their mother. They were concerned that she was not eating or taking her medication properly. Approximately one year later, all of her assets had been exhausted.

Medicaid assistance was applied for. Along with the SRS social worker, I screened her, only to find that she was not eligible for nursing home care. Her house and all her personal belongings had been sold at auction.

There are no group living situations in our community. If we had followed the regulations in their strictest interpretation, she would have had to leave the nursing home with no cash reserves and find a place to stay. However, had she had assistance with personal care, medication assistance and meals on wheels, this probably could have been prevented. Instead, we allowed her to remain in the nursing home for the Medicaid program to subsidize her care.

The HCBS program has many shortcomings. You are not eligible for the program unless you are determined to be nursing-home eligible. Second, the reimbursement is most often lower than it costs to provide the service, thus discouraging providers. Third, most people don't know the service exists until they are already in a nursing home and have no home to return to.

There is much work to be done and many unknowns in looking at long-term care. However, the need is here and will only continue to grow. We must address these needs with quality, cost-effective service. Providing maintenance care in the home will not only prevent premature institutionalization (thus saving dollars in the Medicare and Medicaid programs), but it is the best way to allow an individual to maintain dignity and self respect.

Testimony of Linda Reinhardt, Member-At-Large of the Kansas Farm Bureau Board of Directors, Manhattan, Kansas

I am here today representing the more than 126,000 member families of the Farm Bureau in Kansas. We want to bring to your attention some of the special needs of the rural elderly. Those needs are in a number of areas, some of the most pressing of which are health care, transportation, taxation and Social Security.

For many of our elderly, nursing home care will become a necessity. For others, remaining in their own homes will be a far preferable option. We believe health care programs should maximize the independence of the elderly for as long as possible.

In health and nutrition many things are needed. I will highlight but a few. We support:

- Legislation to allow 100% federal income tax credits or tax deductions for those who self-finance their health insurance.
- Greater use of non-physician providers to help relieve personnel maldistribution in the medical profession.
- Efforts of medical schools to train additional qualified family physicians who intend to practice medicine in rural areas.
- Economic inducements to encourage doctors to practice in rural areas. Along with the Kansas Medical Society, the Kansas Farm Bureau has initiated a program known as MEDISERVE. Our program provides financial stipends for candidates at medical school who will agree to practice in an underserved rural area of Kansas in one of the basic general practice/family practice specialties.
- State and federal government policies that provide incentives for medical and mental health services in rural areas.
- Efforts **at every level of government** to reduce medical malpractice insurance costs.
- Third-party payer recognition for payment of outpatient treatment and preventive measures.

While still on the topic of health and nutrition, I must say to you that we are **opposed** to compulsory national health insurance in any form.

One of the things we have done in Kansas that should be reviewed as a possibility at the congressional level, something to dovetail with our new Kansas law, relates to what we call Division of Assets.

Because medical care, medical assistance, and nursing home care are becoming increasingly expensive, those types of care often deplete the assets of both rural and urban families. That depletion threatens to bankrupt families. We urge this Committee and the Congress to give careful consideration to legislation which might be developed to protect against such financial disasters. We believe legislation at the federal level, similar to what was passed in Kansas just this year, should permit spouses to divide their income and resources, including cash or other liquid assets and real and personal property, in order to become eligible for or to remain eligible for medical assistance or nursing home care.

Transportation

Adequate transportation is tremendously important to our rural elderly. In this day and age, when more and more bus line consolidations are taking place, and less and less bus transportation is available in many communities throughout Kansas and throughout the nation, we believe this matter deserves serious attention by the Congress. We should have a national transportation policy that indicates a willingness to find a shared responsibility for providing such service.

The beneficiaries of a good transportation system are not just the elderly. They include retail business and service providers when the elderly must leave their community and go many miles for the service or to be a consumer in another community. When fares and tariffs are not sufficient, there should be some method of tax-supported transportation assistance. Surely, we can find the ways to give direct or indirect government assistance to bus lines and other modes of transportation to assist our rural elderly. Of course, rail passenger service is almost non-existent. Perhaps some of our rail lines can be revitalized.

Taxation

The tax policy in this country should be designed to encourage private initiative, economic growth, equity and simplicity. We have not seen that. A number of things could be done to our tax code to simplify and to encourage growth, to encourage capital formation for use in our later years. We would support revisions in the federal tax code to provide income tax averaging. That is vital in agriculture when our income certainly has its ups and downs.

We would support a provision to allow self-employed taxpayers to deduct the full cost of their health insurance premiums.

We encourage Congress to reinstate capital gains treatment. When someone has acquired a capital good and for any reason must sell, the treatment of any capital gain as ordinary income is punitive. We support an exemption from social security taxes for that portion of a self-employed person's income that is attributable to return on investment.

One of the things you as a Committee could do, could recommend to your colleagues in the Congress, that would assist the rural elderly and all other citizens, would be to provide for—**insist on and help develop**—a BALANCED BUDGET. We can balance the budget and still provide the necessary services for citizens of all ages.

Testimony of Arthur J. Spies, Administrative Director, National Institute for Rural Health Policy, Des Moines, Iowa

The National Institute for Rural Health Policy was established in 1986 and is sponsored by the Iowa Hospital Education and Research Foundation in association with the University of Iowa Center for Health Services Research. The Institute is a nonpartisan research center whose mission is to affect rural health policy and improve the health status of rural Americans.

Initiatives of the Institute include policy analysis and applied research, educational activities, demonstration projects and information dissemination. The Institute initiatives are focused on four broad areas of concern:

- Access to rural health care services;
- Care of the rural elderly;
- Rural maternal and child health;
- Rural occupational health.

Both the Iowa Hospital Association and the National Institute for Rural Health Policy are concerned with access to rural health care services and the special and changing needs of the elderly in rural America.

Status of Rural Health Systems

Before I describe rural health and medical services trends, we first need to put the rural health care system into perspective.

- Nationally, 47 percent of the hospitals, 23 percent of the beds, and approximately 20 percent of the admissions, patient days, surgery, emergency room outpatient visits, and births are provided by this nation's rural hospitals. The rural hospitals employ about 16 percent of the hospital personnel and generate 13 percent of the expense.

- In Kansas and in Iowa, the importance and contribution of rural hospitals can be doubled. Eighty-five percent of Kansas hospitals are rural and contain 58 percent of the beds and generate 48 percent of the admissions, 51 percent of the days, 41 percent of the surgeries, 47 percent of the emergency room outpatient visits, 44 percent of the births, employ 41 percent of the hospital personnel, and generate 37.7 percent of the expense. Figures of Iowa's rural hospitals are very similar to Kansas.

- Since 1980, the health care system—particularly the rural health care system—has undergone unprecedented dramatic change. At the federal level, implementation of the diagnosis related group prospective payment system and heightened regulation of the practice of medicine through PRO

utilization review have dramatically affected the operations and finances of rural hospitals.

- Nationally, from 1980 through 1986 hospitals admissions dropped 7.5 percent and patient days dropped 14.5 percent.

- In rural America, there were 30 percent fewer admissions and 28.5 percent fewer patient days in 1986 than in 1980.

- More profound reductions occurred in Kansas and Iowa. During that time, growth in outpatient activity and long-term care—particularly Medicare's swing bed program—also occurred. In addition to changing utilization of hospitals, rural hospitals have faced changing payment systems that provide inadequate and inequitable payment for services provided to the rural elderly.

- As of April 1, the payment differential in Iowa was 33.5 percent less for Iowa's small rural hospitals than for their urban counterparts.

- In Kansas, small rural hospitals are typically receiving 27.2 percent less than urban hospitals.

- Payment increases in the Medicare program have not kept pace with expenses. Reduced utilization, coupled with strict utilization review, has resulted in sicker patients being admitted to rural hospitals, requiring additional resources for treatment and longer lengths of stay. Medicare payment increases have fallen short of inflation; therefore, expenses in Iowa rural hospitals have increased faster than net revenues (the money hospitals actually receive for patient services) resulting in an erosion of profit margins. Profit is a misnomer. Iowa rural hospitals have consistently lost anywhere from 2 cents to 6 cents on every dollar of patient care revenue received since 1982.

- Rural hospitals face other problems, such as facility and equipment obsolescence and compliance, limited access to long-term and short-term capital, medical and technical personnel shortages, the level and scope of governmental, payer and voluntary regulation, and changing demographic base and community needs, such as the aging of rural America. These changes have taxed America's rural hospitals. Since 1982, 137 rural hospitals have closed. Those hospitals contained 6,469 beds. More importantly, the number of hospitals that have closed annually is increasing. In 1982, 14 rural hospitals closed, and in 1987, 40 hospitals closed. This points to the seriousness of America's rural hospital operating environment.

- The long-term strategic issue that rural America and rural hospitals face is the aging of rural America.

- Nationally, the elderly represent 11.3 percent of the population, but by the year 2050 more than 1 out of every 5 persons will be 65 years or older. In the rural midwest, the elderly account for a greater proportion of the population.

- In Iowa, 14.1 percent of the population is over age 65. Over 27 percent of Iowa's counties are reporting an elderly population in excess of 18 percent; 42 percent of elderly Iowans reside in rural areas.

- In Kansas, 13 percent of the population is over age 65; 38 percent of the Kansas elderly reside in rural areas.

- The fastest growing population group is persons over 75. Presently, this age cohort makes up 4 percent of the total population. By the year 2050, their proportion is expected to double. Generally, individuals in this age group are more likely to be female with few assets and often are dependent upon family or outside agencies for assistance in activities of daily living. This group is of particular interest to policymakers since they are the largest users of publicly financed services and programs.

- The elderly consume a disproportionate share of acute services. In Iowa, 14 percent of the population consumed 30.7 percent of the patient days. Most of that acute care is for chronic illnesses such as heart disease, arthritis, hypertension, hearing and vision impairment, orthopedic problems, diabetes, and cognitive impairment.

- As rural America ages, the needs of the elderly are also changing. In addition to acute care needs, other health care, social or life style services, and transportation services are now needed to keep the elderly in an independent noninstitutional setting. These new services will create financial challenges for both public and private sectors.

Health Issues and Needs of Rural Elderly

As part of our concern of access to health care services to the elderly, representatives of elder advocate groups in Iowa, including the American Association of Retired Persons, Area Agencies on Aging, State Department of Elder Affairs, and Council of Senior Citizens advise the Iowa Hospital Association of several problem areas and needs of the elderly.

- After-hospital care is not readily available because of lack of payment and prohibitive regulations on the acute care side.

- There is a need for better discharge planning and better coordination of services and sources of service information for the elderly.

- There is a need for portal to portal transportation services, lifeline services, education on Medicare supplemental insurance policies, various provisions of Medicare, including PRO review, and awareness of various preventive, screening, diagnosis and treatment services.

Because of changing demographic characteristics and budget limitations, transition by rural health providers and payment for these new services is slow or does not exist. The overarching problem is the lack of coordination of services for the elderly. The need exists to create a central agency or organization that will coordinate all services available to the elderly within the community. The agency must be easily accessible and should be recognized as the initial point of contact for information and referral to other resources. Local hospitals, especially those located in rural areas, may be the most appropriate organization to fulfill this need. While coordination of services is important for all elderly, it is particularly important for the rural elderly who tend to be older and more likely to be isolated, both geographically and socially, than their urban counterparts.

Strategies to Improve Access to Health Services by the Rural Elderly

Strategies which have been pursued by hospitals and others to ensure access are many and varied based on community needs and resources.

- Rural hospitals have responded by consolidating inpatient services into an appropriate economic size striving to use existing resources more effectively, such as using multiskilled personnel, thus reducing the number of personnel, and, of course, using fewer beds.

- By recruiting needed physicians (both primary care and specialists) and establishing periodic specialty clinics in such areas as orthopedics, cardiology, otolaryngology, and ophthalmology.

- Rural hospitals have diversified their revenue and service portfolios along the health care continuum. The swing bed program, other long term care, outpatient care services, home health care, day care, and supervised independent living for the elderly are several of the programs being pursued.

- Rural hospitals have implemented many different programs for the elderly, such as health lifeline programs, meals-on-wheels, congregate meal sites, wellness programs, screening programs, education programs, and transportation services.

- Rural hospitals are networking, investigating and, if appropriate, pursuing multi-institutional multiprovider arrangements including shared services, cooperatives, joint ventures, affiliations or networks such as VHA and management contracts.

- The sixth and most important strategy pursued by hospitals is defining and implementing a new mission and business focus. Rural hospitals are expanding the mission and business focus of the hospital into a health and social service center, functioning as the hub of the community health and social service system.

These strategies by rural hospitals are being pursued not only in Iowa, but in Kansas and across the country. As I mentioned earlier, the critical problem is the lack of coordination of services. One method for coordinating services to the elderly is through comprehensive case management. The goal of case management is to coordinate access and provide necessary community services to frail and vulnerable elderly, therefore helping them avoid unnecessary utilization and inappropriate nursing home placement. This is achieved through review of cases by a case management team made up of members from all the area agencies which provide services for the elderly. A case plan is developed with the cooperation of the client and the family. This approach is a good way to maximize service provision, particularly in rural areas where resources are scarce.

An example of a successful case management effort has been undertaken in Linn County, Iowa. Fourteen community agencies in Linn County have joined together to operate the multidisciplinary Linn County Case Management Project. Through this project, a variety of services are offered, including adult day care, home health care, transportation and acute care services. Since its inception in 1982, the number of cases being managed has risen from 23 to over 100. Results of this program have been that service delivery has been enhanced, quality of life has improved, and costs have been reduced by 50 percent. There is no payment for this service; therefore, only a limited number of elderly can be served.

A second innovative strategy being developed by the auxilians of Iowa hospitals will assist the elderly in completing and understanding Medicare payment forms. This is a project undertaken by the auxiliaries during their 1988 program year. Training programs for auxilians from each hospital were held during February 1988. Implementation of this program is being determined by each auxiliary.

What Is Needed?

Many of the health related needs of older adults are not strictly medical. These people also require education, coordination of services, transportation, support services and custodial care. The structure of our health care system is mismatched to the needs of the elderly. Financial and regulatory incentives do not exist which allow the development of a community-wide network which offers, as Ken Dychwald describes it, "a diversified spectrum of health and social services in a community-wide integrated network driven by a one-stop-shop case management system."

We would recommend the following actions for Congress's consideration:

- Adoption of a federal health policy to allow and encourage rural hospitals to be the focal point for health and social service provision. Removing payment or other regulatory obstacles is also critical.

- Transportation and social services for rural America should be underwritten sufficiently to assure access to and coordination with acute, emergency and long-term care services.

- Payment to rural hospitals for Medicare patients must be increased. The inequitable payment difference between rural hospitals and urban hospitals must be eliminated.

- Adequate payment for nonacute care services is imperative. Federal policy has encouraged less inpatient acute care and more outpatient care, long-term care and home health care. Adequate payment for these nonacute services must follow.

- Rural providers must have regulatory and payment flexibility. Regulatory obstacles blocking rural providers from quickly responding to changing community needs must be eliminated. Conflicting regulation in payment policies must be identified and eliminated.

- A federal health care and social policy for the elderly needs to be developed. The policy should recognize the need for financial and geographic access to health care all along the health care continuum and the existence of proper financial and regulatory incentives allowing the development of health, transportation, and social services needed by rural America's elderly.

- Rural hospitals should be encouraged to convert idle acute resources to other health care services needed by the elderly and the poor. While a federal grant program providing financial assistance to rural hospitals in converting idle capacity was legislated last year, funds need to be appropriated for that grant program. Small rural hospitals need that financial assistance for the conversion of idle capacity, training of existing personnel and recruitment of new health care professionals.

The leadership role in setting policy and financing must come from Congress. A strong national policy and funding mechanism for health, transportation, and social services needed by rural elderly will encourage state, local and private development.

Our current concerns are for the continued availability and access to quality services by rural Americans, especially the rural elderly. As suggested earlier, America's rural hospitals are providing diversified services to better serve their

communities. The future rural hospital does need to continue to provide smaller amounts of acute and emergency care. To remain viable, however, especially in sparsely populated areas, it needs to be a community health and social services center. The gamut of noninpatient acute care services being provided will increase as rapidly as hospitals and other providers can overcome the various regulatory and financial barriers.

A rural health care system of the future will offer a diversified spectrum of health and social services in a community-wide network driven by "a one-stop-shop case management system." The hospital can serve as the focal point for this network.

We appreciate this opportunity for comment on factors that have inhibited access to health care services by the rural elderly, strategies pursued by rural hospitals and other providers that enhance the rural elderly's access to health and social services, and identification of several initiatives Congress can pursue. The Iowa Hospital Association and the National Institute for Rural Health Policy pledge to work with you in seeking solutions to problems and needs of rural America.

Testimony of Ernie J. Chaney, M.D., Professor, Department of Family and Community Medicine, University of Kansas School of Medicine—Wichita, Wichita, Kansas, and Program Director, Saint Joseph Residency Training Program, Saint Joseph Medical Center

I would suggest to you that there are six areas of great concern in health care delivery to the rural elderly:

- Health manpower;
- Increasing support for Family Practice Residency Training Programs;
- The high cost of medical education;
- The plight of rural hospitals;
- The fee differential paid under current Medicare regulations;
- The increasing medical liability crisis.

All of these factors are closely interconnected. The federal government has certainly been concerned about the supply of adequate numbers of health professionals and the distribution of those individuals. The Graduate Medical Education National Advisory Committee (GMENAC) indicated that there was a surplus of certain types of physicians and that the surplus would exist until the turn of the century. Other studies, such as those done by the U. S. Department of Health and Human Services (ODAM report #4–83, June 1983) indicated that, even taking into account physician diffusion, by 1994 and thereafter there will be a large deficit in the physicians required to meet the federal shortage area minimum levels in both nonmetropolitan areas and metropolitan areas.

The Council on Graduate Medical Education (COGME) has been examining both the supply of and demand for physicians, with its preliminary conclusions specific to primary care specialties of general internal medicine, general pediatrics, and Family Practice. In its preliminary recommendations, COGME has concluded that "there is an undersupply of physicians in Family Practice." COGME then recommends that "incentives such as grant programs, revisions in Medicare and Medicaid reimbursement policies and student loan repayment programs must be provided to assure that sufficient numbers of primary care residency programs and positions are available to meet the needs of society."

On a more personal note, I can report to you that the state of Kansas is greatly in need of Family Physicians. Many letters have been written to me as Program Director from communities seeking Family Physicians. The federal government has been concerned about these health manpower needs and has been responsive to those needs by the implementation and support of federal programs such as the Public Health Service Act, specifically Sections 780 and 786. I would strongly encourage this committee and other members of Congress to support Senate Bill 2229, the Health Professionals Reauthorization Act of 1988, which was introduced on March 29 by Senator Kennedy. This bill continues to fund Family Practice residency training programs for three years and will soon be considered by the

Senate Labor and Human Resources Committee. My understanding is that Representative Waxman is drafting reauthorization legislation which will be introduced in the House and which I believe you should strongly support. While my political convictions are that a balanced budget would be helpful for all of our citizens, appropriations of $36,000,000 for Section 786 and $7,000,000 for Section 780 would certainly be a wise expenditure and one that would benefit the rural elderly.

Another area of great concern is the plight of rural hospitals. "These hospitals are impacted by increasing amounts of indigent care, bad debts, and reduced opportunities for public support through tax revenue and donations." (Rural Hospitals: Literature Synthesis and Health Services Research Agenda, Rural Health Services Research Agenda Conference, San Diego, California, December 13–15, 1987)

The second problem for rural hospitals is their inability to respond to pressure created by the evolving American health care system. These include restricted reimbursement by public and private payors with the resulting conflict between cost containment and access, shifting the locus of care from inpatient to outpatient settings, inadequate supply of health personnel in rural areas, increasing competition for patients, and increasing need for capital by these institutions. All of these factors help to explain why many rural hospitals are experiencing economic distress and are considering or implementing plans for closure. (Ibid.)

Supportive legislation such as the Rural Health Care Improvement Act (SOBRA) are useful as well as legislation which would eliminate the urban-rural differential in hospital reimbursement by Medicare. Most rural hospitals have fewer than 100 beds and will require specific individual attention to prevent communities from losing their hospitals.

Another issue to which I draw your attention is the practice of specialty differentiation in Medicare reimbursement. Recently the Health Care Financing Administration (HCFA) posted a notice in the Federal Register requesting comments on a possible change in regulations that govern the determination of reasonable charges that Medicare pays for physicians. I urge that all of you support action to formally eliminate specialty differentials through the regulatory process.

Another area of increasingly great concern is the medical liability issue. I have enclosed in the printed material testimony given to the Kansas House and the Kansas Senate Judiciary Committees concerning that serious crisis. This will not only affect the health care delivery of all reproductive age females in Kansas, but will also add the possibility of closing rural hospitals, which will certainly impinge on health care for the rural elderly.

Some years ago I testified before Senator Dole's subcommittee concerning medical liability and specifically requested that the federal government refrain from action on the liability issue and allow each state to develop their own solutions. However,

it has become abundantly clear that at least the state of Kansas is unable to do that, and unless some solution is found to this extremely serious problem, a change in the health care delivery system which will be devastating for rural inhabitants will surely occur.

Lastly, the recruitment and retention of Family Physicians to rural America is essential if we are to maintain the high quality of medical services that that population deserves. There are currently 382 approved residency training programs in the specialty of Family Medicine and, as I have previously stated, they will need support from both state and federal governments for their continued existence. It is important that we recruit medical students into the specialty of Family Medicine to serve in rural areas, and many medical students now complete their graduate training with debts in excess of $35,000. Because of the high cost of medical education, they may enter specialties which can afford them a greater chance for paying these high debts. In both academic medicine and private practice, Family Physicians are at or near the bottom of the income levels for physicians. Some attention needs to be focused on this problem.

Additional aid to encourage rural practice may be necessary in the form of increasing the support for student loans with forgiveness of those loans for serving in underserved areas. It may also be helpful to develop income tax or other incentives to help recruit and maintain physicians in rural America.